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DRUG ABUSE IN THE MILITARY

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

REVIEWING THE PROBLEM OF DRUG ABUSE IN THE MILITARY

JUNE 27, 1985

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DRUG ABUSE IN THE MILITARY

THURSDAY, JUNE 27, 1985

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS AND ALCOHOLISM, OF THE
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:05 a.m., in room SD-430, Dirksen Senate Office Building, Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senators Hawkins, Grassley, Nickles, and Dodd.

OPENING STATEMENT OF SENATOR HAWKINS

Senator HAWKINS. Good morning.

Today, the Subcommittee on Children, Family, Drugs and Alcoholism will examine a problem of devastating significance: "Drug Use in the Military." U.S. citizens are fortunate, indeed, to have the finest fighting forces in the world. They are the best trained, the best equipped, and the best disciplined. They are the most courageous military troops on Earth. They have proven U.S. superiority in every way from minor skirmishes to world wars for more than two centuries. The U.S. military should be ready, but an enemy has crept into the camp. This enemy pays no attention to rank; the enemy attacks and destroys enlisted personnel and officers alike. The enemy leaves in its wake, a military that cannot be ready and cannot respond. The enemy makes our troops inefficient and causes slowdown. The enemy causes breaches of security, safety, and death. The enemy slows performance. The enemy alters split-second judgment. The enemy is substance abuse—both the use of illicit narcotics and the abuse of alcohol. Both abuses must be addressed immediately and effectively.

After the Vietnam conflict, the statistics were released vividly demonstrating the appalling and unacceptable rate of drug abuse in the military. In 1981 a study by the Pentagon showed that 27 percent of junior enlisted men used marijuana; 9 percent used amphetamines; and 7 percent used cocaine. Drug use by young Americans has dramatically increased since these figures were first released in 1981.

Has a parallel increase occurred among our military forces similar to the increase among our population?

I am angry to have to tell the American public that we do not know, if there has been an increase.

As chairman of this subcommittee, I have repeatedly asked for figures on drug use in the military. I am also aware of other congressional subcommittees that pleaded for some kind of statistic, some kind of information regarding substance abuse in the military. All of this effort by all of these people and not one satisfactory response.

The scope of the problem of drug abuse in the military remains unfathomable. Each year they change the testing procedures. Each year the directors of the responsible offices are changed. Each year the computation formulas are changed. No one outside the Department of Defense has been able to set a trend line to demonstrate any progression whatsoever.

It is a bit like trying to compare apples to oranges which everyone knows cannot be done. The Department of Defense is protecting this secret.

I want to know; other Senators want to know, Congressmen want to know, the public deserves to know how prevalent is the use of illicit narcotics? How many of our fighter pilots abuse alchol? How many use cocaine? How many smoke marijuana? We need hard evidence. All that we have now is anecdotal evidence, and that does not bode well.

The tragic crash aboard the U.S.S. *Nimitz*, killing 14 servicemen, was caused in large part because of drug abuse by members of the flight crew. The 1984 Military Readiness Report indicated a dramatic increase in military dismissals due to drug abuse, especially in the Marine Corps.

The 1984 drug raid at Fort Belvoir which netted 70 servicemen charging them with crimes ranging from possession of cocaine to selling marijuana. If there is good news, if drug use has gone down in the military, as is claimed with the results with the Voluntary Drug Prevalent Survey, then why in 1984, were there 18,637 dismissals from the armed services for drug and alcohol related problems?

Why were there 35,514 U.S. Army soldiers tested positive for drug use in 1984? Why were there 8,055 members of the U.S. Air Force tested positive in the same year of 1984? And why did the U.S. Navy, in the year 1984, test as positive, 60,024 of its service men and women?

What is the secret being kept by the Pentagon?

Drug abuse in the military is a health problem. It is a morale problem. It is a manpower problem. It is a military preparedness problem.

It is a problem for the American citizens who support military preparedness for freedom's sake. United States citizens must have trust and confidence in the men and women who serve them in the military.

To be prepared and ready, members of the military must say, that drug abuse has no role in the military, none. There has been a lot of effort on the part of many of the military services and in the Department of Defense to try to rid the services of the evil threat of substance abuse.

Has the effort paid off? I particularly commend the Navy, which is uniformly recognized as the service that has done the most to keep its house in order. Under the direction of Secretary Lehman, the Navy has adopted, the Navy is living by the slogan, "Not on my watch, not on my ship and not in my Navy." Today, the Navy does the bulk of the military urinalysis testing—viewed as the greatest single deterrent to drug abuse in the military.

How much more needs to be done? Unfortunately there has been a deemphasis on drug and alcohol abuse programs within the Office of the Secretary of Defense. We want that changed. There is an over-emphasis on the results of the Drug Prevalent Survey which is both voluntary and anonymous. This subcommittee demands more solid information.

We are here today, to discuss what has been done and what we can do to continue to address the real threat, the enemy within—"Drugs in the Military."

Senator Dodd.

Senator DODD. Thank you very much, Madam Chairman.

Let me commend you for holding these hearings. As you have noted, there is an awful lot of anecdotal testimony associated with the problem of drug abuse and alcohol abuse within the armed services. Some testimony is exactly reflective of the problem and others, I am sure, exaggerate the problem significantly. I am delighted that you made note specifically, of the Navy's efforts. We have some 13,500 Navy employees at the submarine base in Groton, CT and when the commanding officers there recognized the problem in 1982, they began to take immediate steps to educate, eradicate, and deter, the problem of drug abuse. And as a result of those efforts, the Navy tests three or four times a year for drug abuse, but the incidence of drug abuse among all employees at the Atlantic subforce, which includes the installations along the entire Atlantic seaboard, is less than 1 percent and for crew members on submarines, it is less than one-half of 1 percent. So that while it is still a problem, it has dropped significantly. And as you pointed out, that is no small measure due to the efforts of the Navy to eradicate this problem, that is drug abuse. Unfortunately, we do not know as much about alcohol abuse and I suspect that that is as serious a problem. We have had a tendancy to focus on the drug question because of the nature of the substance, and the illegality of it, whereas, with alcohol we are not talking about an illegal substance, but the abuse of a legal substance, and the problems associated with that. So we know less about that particular problem and yet, obviously, the effects on a person who is intoxicated from overindulgence of alcohol is no less a serious problem than a person who is not fully functional as a result of the use of narcotics.

So I commend you today for holding these meetings and I look forward to the testimony of our witnesses. I hope that we can really get to the heart of how serious the problem is so that we can intelligently deal with it. It is the kind of story that we can exaggerate out of all proportion and I think that our interest here is to find out what those facts really are and what we can do to help so that as you point out, we have a military that is fully prepared to engage in whatever activities that they should have to. This is, obviously a national security issue of significant proportions. So, I thank you for holding these meetings.

Senator HAWKINS. Thank you, Senator Dodd.

We will include in the record at this point statements by Senators Grassley and Kerry.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR GRASSLEY

Senator GRASSLEY. Madam Chairman, I commend you for holding this hearing as we examine the state of affairs of the prevalence of drug and alcohol abuse among military personnel and the impact on combat readiness. I look forward to determining what drug detection and interdiction efforts are being made in keeping with our commitment to building a strong defense.

I want to emphasis my commitment of getting the most and best defense for our taxpayer dollars. All my activity in defense has been related to accomplishing this goal.

Therefore, it concerns me that among all the other problems, we are investing thousands of dollars in the training of military personnel, who because of drug abuse, render ineffective their use of military equipment, jeopardize our national defense and the lives of others.

I look forward to testimony revealing the extent of this problem Additionally, I am looking forward to hearing from Dr. John Beary, associate dean and director at the Georgetown Medical Group here in Washington who is also from Iowa.

SENATOR JOHN F. KERRY

SENATE LABOR AND HUMAN RESOURCES COMMITTEE

Madame Chairman, I am pleased that you are holding this hearing on a critical problem plaguing our armed services; the tragic abuse of drugs and alcohol by our military personnel.

The painful reality of drug and alcohol abuse in the military brings to mind the following question: To what extent does low morale result in substance abuse?

During my tour in Vietnam - a war with an unclear purpose - I witnessed soldiers uncertain of their military mission; platoons unsure of the cause for which they were fighting; leadership that was often misguided and misdirected; and I witnessed the tragic results - a military lacking morale. Lacking a sense of mission and commitment, American soldiers overwhelmingly reverted to drug use.

Today's military also appears to often lack high morale and purpose, which strongly suggests a need to investigate the correlation between morale and alcohol and drug abuse.

We must eradicate any drug use in our armed services. Statistics show that in recent years, from urinalysis tests and surprise inspections there has been a dramatic decrease in drug abuse. But defense officials have noted sharp increases

IN HEAVY DRINKING AND ALCOHOL ABUSE, THUS INDICATING A SHIFTING OF THE PROBLEM OF SUBSTANCE ABUSE FROM DRUGS TO ALCOHOL. PUNITIVE REMEDIES HAVE PROVEN EFFECTIVE IN LESSENING DRUG ABUSE. BUT DOES THIS ADDRESS THE REAL PROBLEM? THE NECESSITY TO ADDRESS THIS ISSUE IN A FAR REACHING MANNER SEEMS OBVIOUS; WE MUST INVESTIGATE THE FUNDAMENTAL PROBLEMS INHERENT IN THE WHOLE MILITARY SYSTEM.

MADAME CHAIRMAN, THIS COMMITTEE MUST BE DILIGENT IN ITS EFFORTS TO GET TO THE CAUSES AS WELL AS THE SYMPTOMS OF THIS PERVASIVE SUBSTANCE ABUSE PROBLEM PLAGUING OUR MILITARY.

I AM VERY MUCH LOOKING FORWARD TO THE TESTIMONY OF TODAYS WITNESSES.

Senator HAWKINS. Our first panel will give us an inside look at the military substance abuse problem.

Each of these men were directors of drug and alcohol referral and treatment programs at important U.S. military bases Andy LaPlante was Clinical Director of Counseling Centers at NATO Supreme Headquarters Allied Powers, Europe. The abbreviation, I believe is SHAPE. Andy, I am proud to say, now works at one of the most successful drug and alcohol rehabilitation centers in my State, Florida, Village South in Miami and we appreciate your service.

Jim Mays was the Chief of the Social Actions Office at Offutt Air Force Base. Offutt is the home base of the Strategic Air Command. Jim is now Director of the Immanuel Alcohol Treatment Center in Omaha, NE.

We will hear first from Jim Mays.

STATEMENT OF CAPT. JIM MAYS, USAF (RET.), DIRECTOR, IMMANUEL ALCOHOLIC TREATMENT CENTER, OMAHA, NE, ACCOMPANIED BY SFC. ANDREW H. LAPLANTE, USA (RET.), DIRECTOR OF PLANNING AND DEVELOPMENT, VILLAGE SOUTH REHABILITATION CENTER, MIAMI, FL

Captain MAYS. Thank you very much.

First, I want to thank you for the opportunity to participate in the review of the possible solutions of what I see as a devastating problem. I am not here to throw stones at an organization that I feel to be proud to be associated with for the past 25 years. However, I do believe that seemingly good solutions are often times enemies of the obvious best solutions.

I have viewed drug/alcohol problems in the Air Force for the past 20 years from three different levels of experience. First, my own personal experience with the effects of alcoholism in my life and the impact that it had on my contribution to the Air Force mission.

My second level of experience related to the observations while serving as chief of the Social Actions Office with responsibility for the drug and alcohol education rehabilitation program at a major Air Force base.

The third area of experience and how it relates to the military problem is that gained in my current position as director of a civilian drug alcohol treatment program that is colocated near a large Air Force installation.

Drug addiction and alcoholism carry with it a set of conditions, three of which I would like to discuss.

One is enabling. Enabling is a process whereby the abuser or alcoholic is supported in their disease many times out of the good intentions of others. The abuser alcoholic needs to be held accountable for their actions if they are to see the true nature of their illness. I have experienced many situations where the enabling process was employed as a protective device for the individual, but actually resulted in them not receiving the help that they needed for their problem.

The second condition is that of denial. Denial is "out of sight, out of mind" activity, whereby many parties choose to ignore the problem. Denial can also take the form of, indeed recognizing the problem does exist, but that it does not exist at an indepth level. Not only individuals deny, but institutions also deny.

The third condition is that of rationalization. When I was involved in alcohol-related incidents in the Air Force and enabling I perceived from my commanders led me to the point to rationalize that my behavior was indeed acceptable to the institution.

While serving as the chief of the Social Actions Office it became obvious that the drug alcohol problem was perceived as a punitive system by most members. Several factors relate to this, including the integration of the Drug Alcohol Program with the Human Relations and Equal Opportunity Programs. In my opinion, these programs in no way should be combined, and the combination, indeed, dilutes the effectiveness of both programs.

I also observed a system that was primarily incident oriented and not an environment to attract the self-referrals for assistance. The program composition was primarily that of younger airmen and younger officers, with some involvement in the middle level NCO ranks, almost all of whom had had an alcohol or drug-related incident.

Virtually no assistance in the form of treatment was provided to senior officers or senior NCO's during that time.

The last area of personal experience I would like to share with you is that derived from my current position as director of a civilian drug alcohol treatment program. Being located near a large Air Force base, we are in contact with active duty members and their dependents who are seeking treatment. Many members who use our services are doing so under the strict confidentiality that we can provide. Their concern is always that the Air Force will not find out about their participation with us. Again, this emphasizes the fear that many members have that the impact of their seeking help will have on their career.

In conclusion, I would like to state that the drug/alcohol problems encountered by the military are seemingly a somewhat higher rate than that in the civilian sector. In the civilian sector we are viewing these problems to be at a near epidemic rate.

The old adage that if a person does not drink on the job, then I do not have the right to get involved is outdated. Most alcoholics or drug addicts do not drink or use on the job; however, their impact on the job influences morale, safety, and productivity.

I would be happy to answer any questions relating to this information that I just covered, or any questions that you may have of me.

Thank you very much.

Senator HAWKINS. Thank you.

You testified that you had personal experience with alcohol abuse and the Air Force's system designed to treat it and stated that you were an alcoholic, correct?

Captain MAYS. That is correct.

Senator HAWKINS. Did the Air Force know that you were drinking?

Captain MAYS. Before I answer that, I would like to say the experience that I want to share is over a 20-year period.

Senator HAWKINS. Surely.

Captain MAYS. But I want to say that I still see some of the same things ongoing today.

I first became aware of my own alcoholism problem in 1965, and it created within me a need to develop a character and a characteristic that I could use to protect myself from the system that I was involved with at that time. During the next 10 years, there were several occasions where my drinking came to the attention of the military. The first time was in 1970, when I was serving as the commander of the intercontinental ballistic crews. I went to the flight surgeon asking for help and at that time, he told me that he did not want to document it because it would impact on my career, and everything associated with that. It would be devastating on my career to the point of possibly being asked to leave the Air Force.

He did refer me to an anonymous self-help group at that time, which I participated with off and on for a couple of years.

In 1975, I was arrested by the California Highway Patrol for driving while intoxicated. At that time, the only activity that took place in relationship to this was the loss of my driving privileges on the base for 2 months.

My commander, at that time, rationalized again, that the highway patrol were really out to get us—the military—in this area and that I was a victim of circumstances. I again, took that as a part of my own rationalization that my commander accepted it, so that therefore it was OK.

Approximately 18 months later, I was arrested again for a second DWI in the State of California, The only action taken again at that time was loss of base driving privileges plus a reduced officer efficiency rating, but to a very slight degree.

At that time, I had to look at the problem myself and decided to act on it, and became again a member of this anonymous self-help group and have been sober since that time.

Throughout this entire process, I was not asked to go for an evaluation or take part in any rehabilitation. I think that one of the reasons being that through my alcoholism, even though it was rampant, I was a highly productive member of the military, and I did my job, did it well. The comment that I made about the person not having to drink on the job to be alcoholic, I really believe that because in my opinion, the alcoholics when drinking use the alcohol as their solution. When they are not drinking is when they have the majority of their problems. So if the alcoholic does not drink on the job, he is still having problems associated with his disease, and carrying these problems into the job.

Senator **HAWKINS**. Well, you mentioned the Social Actions Office, and what does that office handle?

Captain **MAYS**. The Drug Alcohol Education Rehabilitation Program, Human Relations Education Program, the Equal Opportunity Program, and the organizational assessment program.

Senator **HAWKINS**. What gets priority?

Captain **MAYS**. I think it is based on the director of the program or the chief of the program's orientation, plus factors related to all the problems at a given installation. In my case, I had to devote about 80 percent of my time to the Human Relations, Equal Opportunity Program.

Senator **HAWKINS**. Do you feel that there should be a separate drug and alcohol office?

Captain **MAYS**. I most definitely do.

One of the reasons being a negative transfer type of situation. A mental transfer in that—if a person has had a certain feeling toward the Human Relations Equal Opportunity Program, and they need the Drug Alcohol Program to assist them, they tie the two together and it can create some negative attitudes.

Senator **HAWKINS**. You testified about the alcohol, you feel alcoholics are common in the service, would that hold true for pilots in your experience?

Captain **MAYS**. I have had personal experience working with pilots. In our center and other local control pilots—and others—have taken leave from the military and come to our civilian treatment center to get the help and even to the point of not even using CHAMPUS or other type of reimbursement methods. They pay out of their own pocket, again, so that they can control the confidentiality. They do not want that information to get back to the Air Force.

Senator **HAWKINS**. What is the rate of cure of those who come to your center?

Captain **MAYS**. Approximately 65 percent, 2-year sobriety.

Senator **HAWKINS**. And how long does your program last?

Captain **MAYS**. Our program is 28 to 30 days basic with a follow-up after care program for 6 months and then an informal after care for continuation of the 2 years. Also emphacis is given to the lifelong recovery AA can give.

Senator **HAWKINS**. Do you feel that the official position by the Air Force brass deters the military to come for help?

Captain MAYS. That is a hard question to answer.

I see some very good things happening in the process, particularly the education process and identifying the problem are there. Primarily as I see it, the problem is based on the complexity of the players. The environment of handling the drug addict or the alcoholic with a system utilizing the local commanders and their input, the supervisor's input, the capabilities of the social action staff and so forth is such that the complexity of decisions allows the alcoholic to find the loopholes. On some occasions when I was serving as Chief of Social Actions, I had to deal with commanders who saw the problem as a moral issue, I had to deal with them in one specific way in relationship to their ideals. I have worked with other commanders who were very knowledgeable of the system and very effective in removing the denial and enabling as a part of the process. The people who happened to be involved with those commanders had very successful treatment. Some of the others did not because of the personal biases associated with the problem with the individual commander.

Senator HAWKINS. So that it depends on the individual commanders' attitude?

Captain MAYS. In a lot of ways.

Senator HAWKINS. Are the enlisted personnel treated differently than the officers?

Captain MAYS. My experience has been yes, in some cases. I have had opportunities to deal with senior officers in the civilian environment and the system has advised them that maybe they ought to take that route rather than going through the system.

Alcoholism cuts across all the levels of status and personalities. The numbers indicate more treatment involvement with the younger members. I think primarily because they are easier to identify.

The alcoholic, over a period of time, can develop a very functional protection system for themselves.

Senator HAWKINS. Do you have any evidence of men or women in strategic positions or sensitive positions whose alcoholism is not being treated?

Captain MAYS. Yes, I do.

The specific examples that I know of, are those who are not being treated by the military system but are trying to get the assistance that they need through anonymous self-help groups and through some of the programs that we offer and programs that other agencies in the Omaha area offer.

Senator HAWKINS. How wide would you estimate the scope of the problem to be?

Captain MAYS. I think that it is probably one of the most devastating impacts on the productivity and morale of the Air Force. One area that ties into this is the fact that, as I see it, virtually nothing is done to support treatment for the dependent population. With alcoholism each alcoholic, according to NIAAA's, latest study affects about four different people directly. For example if the dependent member is alcoholic then the military member is taking all of the anguish, anger and resentment that goes with that into the job. Therefore, the military member may not be an alcoholic him or herself, but the impact of the disease is there. He or she is the codependent.

In relationship to that, at Offutt, we had a staff of four counselors to attempt to do something with an expanded population which includes civil service personnel and dependents of approximately 30,000. We could virtually do nothing in relationship to the dependent population.

Again the same attitude holds true in that dependent will not seek the help if they think that it would create an impunity or problem with the military member's career.

Senator HAWKINS. Do you have any proposed solution for the problem of alcohol in the military?

Captain MAYS. I think that first, a single purpose organization to accomplish those goals, should be created. Developing the education processes should be continued. Developing more firm continuation policies so that if the players change, the policy interpretation does not have to necessarily change should be continued. Finally, developing programs for dependents is a very strong need that I see.

Senator HAWKINS. You may be aware that after the *Nimitz* accident and tragedy, they created an Office of Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse Prevention in the Pentagon.

Do you think that that would be helpful to have that to be a permanent position?

Captain MAYS. I would think so if it develops that across-the-board single serve purpose activity.

Senator HAWKINS. Thank you.

Senator DODD. Just very briefly, I think that Madam Chair has covered most of the ground, but let me ask you this, if I could.

Some of the national sports teams, or the leagues, rather I should say, have adopted a proposal of allowing people to come in who are suffering from substance abuse of one kind or another, without any repercussions, fines or penalties, in order to get at the bottom of the problem.

What you have suggested throughout your testimony here, this morning, is that one of the problems is the clandestine nature, people trying to seek help, realizing that if it becomes public information that it could jeopardize their careers in the military.

Do you think that it might make sense to have such a program? Have you talked with anybody in the military about such an idea, and if so, what has been the response?

Captain MAYS. I probably come in contact with 150 to 200 military members a week who are in recovery. Many of them who went through the social action systems, others sought out the assistance themselves, but they all still carry forward a certain fear. I will give you a specific example.

Monday night I had a middle-level NCO approach me. He is a 15-year member of the Air Force, and very productive member of the Air Force now that he is in recovery. He has been in recovery for about 4 years and it is time for him to update his security clearance. His recovery program is forcing a lot of integrity on him—that is part of the recovery process. He asked, what do I do in answering the question about drug/alcohol abuse? If I say, no, I am deceitful. It is not only a violation but it also affects his own integrity. If I say, yes, based on my current job position, there is a possibility that I will lose my clearance and thus not be able to work in the area I like.

Senator DODD. Would he lose his clearance, in your experience, if he admitted that he was undergoing treatment for drug or alcohol abuse?

Captain MAYS. In some cases, yes. However, many people get it back if and when they prove themselves. The real problem is his attitude and distrust of the system.

Senator DODD. What about prevention programs? I did not spend a career in the military, but in my basic training and my advanced infantry training, there were places off post and there was a certain macho associated with your ability to consume and there still is, I think, to some degree. Did you ever hear the expression in the Air Force, "Bottle to Throttle"?

Do you know that expression?

Captain MAYS. Yes.

Senator DODD. That expression "Bottle to Throttle" what does that mean?

Captain MAYS. To me it means, let's get with it in a sense, we fly and fight and drink and everything, it is all mixed in as part of the image that I am dealing in.

Senator DODD. The macho kind of thing?

Captain MAYS. Yes.

Senator DODD. Are there any efforts in the military that you are aware of, particularly in basic training or the AIT part of one's training, the earliest stages of one's involvement in the military to, aside from the penalties that one would face, or the hardships, is there any effort to try and reduce the image associated with one's capacity to imbibe, or to sustain whatever quantities of substances that may be able?

Are there such efforts?

Captain MAYS. Most definitely. In the deglamorization programs, I think have been effective in some ways with that.

Again, part of the problem is the education and early prevention is very difficult because the alcoholic, if they are at that stage, is probably going to ignore that information.

Senator DODD. How about the person coming in? We have seen some pretty alarming statistics that young people who have reached the 12th grade in school systems, Connecticut, for instance, a study done in a six community area around Bridgeport, CT, indicated that by the 12th grade, some 70 percent of 12th graders were—I would not call them regular abusers, but in excess of five to seven times a month were drinking so much so that they were becoming somewhat intoxicated by the 12th grade.

Those numbers, by the way, are not exclusive to the 12th grade, they begin with kids in the 7th grade and work up.

What efforts are made in the military now, to identify during recruitment of those individuals, those young people who already have a problem, before they get to their basic training?

Captain MAYS. Well, that information I do not have, Senator, to the exact nature of what is done, and how the programming is set up and through the interview process and so forth. But one thing that is true, the young people going into the military service represent a cross-section of our society.

Senator **Dodd**. But do you have any information which would indicate, because recruitment levels are important, so we have a volunteer service today and it is important for recruiting officers to be able to meet quotas and so forth, and we realize that has not been a problem in recent times, for a number of reasons.

But what I am getting at, is whether or not we really do make an effort to screen out a problem before, so that the military does not inherit a problem, because of an overly aggressive recruiting officer who wants to make his quotas, and take someone he could suspect, or based on information that he has collected or whatever, would draw the conclusion that this person has already a substance abuse problem.

Captain **Mays**. Again, I do not have personal experience with that, so that I would not want to answer it that way. But, I have dealt with, through the self-help program and other avenues, with young people who state that the way that they answered some of those questions on their induction questionnaires, they could be held accountable for fraudulent enlistment.

Senator **Dodd**. Well, maybe I will save that for some of the other witnesses.

One last question. In your statement you said that the substance abuse problem creates morale problems in the service. Let me ask you this, which is the opposite of that, Does a morale problem in the service create substance abuse?

Captain **Mays**. I do not think so. The alcoholic is going to be an alcoholic no matter what environment they are in. If they are in a good environment they are going to feel better about what is going on, and if they are in a bad environment, it is only going to give the excuses to continue the process.

Excuses such as, "my boss is not understanding" and "the unit is no good" and "I do not like this and I do not like that."

With the alcoholic, you also have to remember that the alcoholic uses the alcohol to celebrate, and to cope. If he or she is in a good unit and morale is high, they still drink alcoholically. Alcohol creates answers and solutions to their problem, no matter what the situation.

The alcoholic will function in any environment, as an alcoholic.

Senator **Dodd**. Thank you very much, Captain Mays.

Senator **Hawkins**. Thank you, Senator.

One last question. The Baseball Commissioner has recommended that the managers, the coaches, and the players all be tested periodically, for drug abuse. Would that be a good idea in the military if we did everybody?

Captain **Mays**. If we do agree that the disease and the use cuts across all phases of our society, then isolating one portion of a group to do that in is part of the process that creates the negative attitude toward the entire system.

One thing related to that. In our experience, in civilian treatment—and since the military is a cross section of our society—we find very few people under the age of 30 or 32 that are not involved in more than alcohol.

Senator **Hawkins**. That have not been involved in alcohol?

Captain **Mays**. That are involved in alcohol plus other drugs.

Senator DODD. Would you repeat that? I did not understand that. There are a lot of people or not many people?

Captain MAYS. Most people under the age of 32 that we are seeing in our civilian treatment process have been involved in more than just alcohol.

Senator HAWKINS. Sure. I can say for the record, that I do not believe that we have ever had a witness in any of our hearings regardless of age, 12, 18, 17, 35, that used drugs without alcohol, they go together.

And the frightening prospect of what Senator Dodd described in Connecticut is across the United States.

In the PAR study, which is a Pannellis County, St. Petersburg profile, probably the most thorough study done of anticipation of what you are going to do in junior high school, the numbers were startling of the large percentage of kids that said, yes, they are drinking; yes, they are going to use cocaine; yes, they do use it at school. Those are epidemic levels, and as you stated, you are just a duplicate of the population at large, a cross-section.

I would say that if these figures continue unabated, you have not seen anything yet.

Thank you very much, Captain.

The next witness is Andy LaPlante, who is from Florida, who was the former Clinical Director of Counseling Centers in NATO.

Welcome, and we would like to receive your testimony at this time.

Mr. LAPLANTE. Thank you, Senator.

My name is Andy LaPlante, and I was medically retired from the U.S. Army in November of 1984, after having spent 12 years in the Alcohol/Drug and Prevention Control Program [ADAPCP]. My assignments in the United States Army have been in every theater of military operation throughout the world, to include my duty in Korea, to Federal Republic of Germany, to CONUS, to NATO SHAPE, Belgium. My duties, while in the military, have included such positions as clinical director, ADAPCP manager, acting ADCO, Research Project Director Behavioral Science. All assignments have been in direct service providing of service members and their dependents for all branches of the Armed Forces, the Department of Defense Civilians, and Department of the Army's civilians also.

I am appearing before this Senate Subcommittee on Children, Family, Drugs and Alcoholism to present my voluntary testimony concerning the scope and impact of drugs in the military and the response of the Armed Forces to those problems during my tour of active duty in the military.

In giving this testimony, I would like to address four major problem areas of concern of the ADAPCP Program of the U.S. Army.

Problem area of urinalysis.

During my duty assignment at NATO SHAPE, Belgium, I was in charge of the biochemical consolidating point for the Benelux area, which handled urine samples for approximately 57 different military units across the four branches of the military. This program was originally under the control of the medical facility that serviced the Benelux area, however, because of the number of inaccuracies, switching of urine samples, miscoding of marked census forms, the program was brought under the direct control of the community counseling center, of which I was in charge.

During my tenure as manager of biochemical testing program, there were many shortcomings of the program testing laboratory, that is the Wiesbaden facility that processes the samples, that caused the credibility of the testing program to be questioned by commanders serviced by the program.

These problem areas included, false positives, and I again repeat, false positives. And retests that did not verify original results that were positive for some other nonrelated drug. Again, retests that did not verify original test results, but came back positive for other drugs. And lengthy delays in turn around results of 60 to 120 days. Also as of January of 1984, the testing lab had stopped testing and issuing substance abuse, substance positives for other drugs except for cannabis [THC].

However, in NATO SHAPE, Belgium area of operation, a study was committed from research done by tracking of urine positives over a 2-year period which show that cocaine abuse had risen 400 percent over the previous year's positives. That soldiers had begun to change their drug of choice from cannabis to cocaine. Further added, that according to USAREUR's own testing reporting system, when testing for cocaine was available, that the NATO SHAPE, Belgium was running 50 percent higher for cocaine positives than all other areas of USAREUR. Urine positives were reported for many soldiers, NCO's, officers, however, justice was metered according to one's rank and the policy of the local unit commanders.

Where one commander might throw the book at a service member for urine positives, another commander would do nothing. As an example, in a unit sweep of a communications remote site, done on a weekend, of a unit consisting of 250 men, 70 men on-duty, 79 on-duty soldiers had positives for cocaine or cannabis abuse.

This included the local commander, but the commander received no disciplinary action, and was only transferred to the Federal Republic of Germany, to another communications remote site. However, enlisted men in that same unit, received article 15's and in two instances, the service members involved were discharged from the military.

Another statistic worth noting, is that better than three-quarters of all the urine positives in our catchment area, that being the Benelux area, were for nonwhites.

The second problem area of treatment programs.

The following remarks—and I want to preface this by saying that the following remarks do not include the alcohol treatment facility at Bad Castada, but are primarily addressed to other 28-day short-term programs in Korea and USAREUR. When a patient or client was diagnosed as having a chronic addiction to either drugs or alcohol, track III clients in the ADAPCP is what we called them, they were entered into residential treatment programs for 28 days. These programs were designed to immediately assist the service member with problem areas of their addiction and returned them immediately back to duty. However, the programs did not meet the expectations of the treatment as envisioned by the local community counseling centers, that of intense rehabilitation and reskilling lifestyles. But, what did occur in these facilities, as viewed by myself, and another clinical director, of another facility upon two surprise inspections conducted on weekends—again if you want to find out what is going on in the military, do something on the weekend when it is shut down—conducted on the weekends was some of the following:

Lack of supervised activities; bowling outings where controlled drinking was allowed; AA/NA meetings where porno movies were being showed; cannabis being smoked on the treatment facilities themselves. Couple this with young inexperienced staff members who had only completed a 12-week behavioral science program, with little training in directional therapy, and what is created is an environment that becomes more of an enabling facility, to the abuser, than a cure. Credibility for the commanders is further lost.

Problem area three is problem area prevention in the DOD schools.

Prevention efforts directed at the Department of Defense Schools have been met with administrative personnel firmly standing in the door and saying that preventions can occur in the community but not in the schools. The Teen Involvement Program, the Chemical People's Program, the SADD Program, the Students Against Drunk Driving Program, was introduced by local community counseling centers during my assignment in facilities in Korea, USAREUR, and NATO SHAPE, Belgium, were refused entry into the schools by school administrators. Their excuse was that they had no problem, however, in at least five health and welfare inspections conducted in student lockers in secondary schools, turned up such items as half empty bottles of whiskey and quantities of cannabis and cocaine.

Problem area four, problem area of the Department of Defense and Department of the Army civilians in ADAPCP.

This program has been in the military since 1977 and before, however, it is the most underutilized program of the ADAPCP. As an example, between July of 1983 and August of 1984, there were less than 171 Department of Defense civilians enrolled in treatment programs for substance abuse for both outpatient and inpatient in all of Europe. Yet, on NATO SHAPE, Belgium facilities, there were 42 reported incidents for the same period involving civilians and alcohol and drug problems, but not one case was referred to the community counseling center for intervention.

While programs exist for civilians, they are not properly manned, as this network of care, as viewed by commanders was not designed to reach civilians, as military members have control of the program, making confidentiality difficult at best.

While commanders have a vested obligation to safeguard the health, welfare, and morale of their men and their families under their leadership, they have an even greater responsibility of safeguarding the national security of our country. Where drug usage is condoned by lack of action or the inappropriateness of over-kill action by commanders, soldiers will receive messages that are mixed at best.

As a member of NATO our allies look to our Nation to take the lead in developing alternative strategies to combat alcohol and drug abuse among Armed Forces serving tours of duty within their countries. It is important that we, as citizens, take a concerned look at these issues and assist where possible through our involvement in suggested plans of action.

I would like to close by saying that there is, in my opinion, existing a major epidemic of drug abuse, and in specific, cocaine, that is presently eroding the heart and core of our NATO commitment, in Europe and that the national security of our Nation is being seriously compromised by our DOD leaders who have refused to deal with the factual insidious infection of this epidemic.

I further call that asks or requests that this Senate Committee look into onsite review—independent review, onsite review—and investigation of the treatment programs in general and prevention efforts of the ADAPCP Program in all of the defense programs. Also, that an independent Senate onsite review investigation of the U.S. Army testing lab in Wiesbaden, Germany be conducted.

And then I have an eight-point strategy that I would like to suggest: (1) That a stronger suppression program be implemented. (2) Uniform administrative and punitive responses to urine positives be implemented. (3) Stronger media response to publicizing urine positives and the action taken in those theaters so that our allies know that we are, in fact, doing something about the problem. (4) Stepped up unit prevention programs through informed awareness to reach not only the soldiers, but the dependents, the Department of Defense civilians and DAC's. (5) Increased urinalysis and biochemical testing, but credible increased urinalysis, and biochemical testing. (6) Continued periodic health and welfare inspections. (7) More responsive and timely processing of urine positives actions. (8) More command contact and briefings on the part of the treatment facilities with commanders.

Thank you.

Senator **Hawkins**. Thank you.

Senator Grassley has joined us.

Do you have a statement?

Senator **Grassley**. Yes. I am here during a recess of the Judiciary Committee in which we are considering the Reynolds nomination, but I wanted to come to bring to the attention of the committee, Dr. John Beary, who is an Iowan and I want to welcome him here and to say that we appreciate his participation. I also want to personally commend the chairman for her outstanding work in the overall drug area, but particularly the use in the military, in pursuit of bringing that problem under control.

I will ask permission to put my statement in the record at an appropriate place.

Senator **Hawkins**. Surely, so ordered.

Mr. LaPlante, you mentioned the problem with cocaine among our troops in Europe, does the military still do urinalysis tests for cocaine in Europe?

Mr. **LaPlante**. When I left the service in November of 1984, cocaine testing was not being done, Senator.

During my tenure at the NATO facility, I issued several urinalysis white papers as I alluded to in my statement, and all four of those papers, and, in particular, my final report were censored and I was reprimanded for assembling that information and making it aware to our local commanders.

And all of those papers were done through collection of urine positives and the trends that were going on with them as well as the people that we were seeing, were credible and viable information, however, I do not feel that commanders wanted it known that that problem had become epidemic proportion in that theater of operation.

Senator HAWKINS. Of the military personnel who you knew about who were using cocaine, were any of them in what you would call sensitive positions?

If so, could you give us an example?

Mr. LAPLANTE. Yes, Senator, they were.

We had an E-4 as well as an E-6, that were involved, one was involved with alcohol, and one was involved with cocaine, and both worked in the war room in NATO, the war room communications area at Otan in NATO itself, in Brussels.

Others at two remote signal places that were in charge of microwave sending of messages. We had four or five individuals that were involved with cocaine abuse and are still in the military and are still assigned in some cases to those particular positions.

Senator HAWKINS. You mentioned the white paper that you wrote in early 1984 on the subject of cocaine use among our troops in NATO. I have seen the study and in the white paper you mention the price of cocaine. That price seems awfully high for someone on a military budget.

Mr. LAPLANTE. Absolutely, Senator, it is amazing to us that young E-4's and E-5's and E-6's on salaries that from an E-4 to an E-6, I guess, would be maybe gross $1,500 and take home pay, if they had dependent's take home pay maybe $500 monthly or $600, excuse me, $500 bimonthly, I am sorry, every 2 weeks, and they had a major addictive cocaine problem, you would wonder how they would be able to support that habit on those type of salaries.

Senator HAWKINS. How do you feel that they do it?

Do you have any evidence?

Mr. LAPLANTE. Either by, I felt Senator, that in two cases that came to light to us, to myself and other counselors, one other counselor, committed in confidentiality that they were dealing in the drugs, themselves, to support the habit by selling it to other people.

And in one particular case, in NATO, the individual never gave up the information as to how and where he was getting the moneys for a $600-a-month cocaine problem and he was an E-4 soldier, possibly making $700 a month, yet, living in a lifestyle that was well beyond that supported his drug problem.

Senator HAWKINS. Of course we have read at the same time, the tight budget that these young men and women are on because they are in a foreign country and on limited salary, prior to their pay raise. I believe that they were eligible for food stamps.

Mr. LAPLANTE. That is correct, Senator.

Senator HAWKINS. Were you there during that period of time?

Mr. LAPLANTE. Would you repeat the question, Senator?

Senator HAWKINS. I had read a lot about these young men and women being eligible for food stamps because their salary was so low prior to their salary increase in 1981.

Mr. LAPLANTE. Well, E-5 and below that had more than two dependents—that had a wife and two dependents—if I remember correctly, would qualify at some point for food stamps, and other social service assistance programs in the civilian sector.

Senator HAWKINS. When you issued the white paper, you state that you were censured for that?

Mr. LAPLANTE. I was verbally censured by my company commander as well as, a letter of reprimand was put into my file for unauthorized studies, or computation of reports that were unauthorized.

They were local reprimands that were removed from my file once I left that catchment area of operation, or supposedly they were supposed to be removed.

Senator HAWKINS. In your opinion, would the use of alcohol or cocaine, heroin, the drugs available in that theater, would that make the members of the military vulnerable to espionage?

Mr. LAPLANTE. Absolutely, Senator.

I think that probably once this committee gets involved in investigating some of these things, that we may see scandals on the proportion of the Walker situation and we may not, but there are a lot of unanswered questions.

How can service members with very low-income support addictive habitual behaviors that are quite costly?

I am from the Miami area and we see, I work for probably the largest treatment facility in the State of Florida, and I am clinical director and director of programming, and we presently have enrolled in our program 116 people in our residential facility, and 82 percent of those are for cocaine addiction, with again, cross-addiction of alcohol and other drugs in 42 percent of those cases. But of those 82 percent that have cocaine problems, that are chronically addicted, they spend anywhere from $700 or $800 a month to $1,500 and $1,600 a month for their problem, to satisfy their problem. That is in the Miami area where drugs are abundant, and has been that Miami is a port of entry for cocaine.

I think that there are statistics floating around on the seizure of cocaine through the Belgium Loc area and the Benelux that would further indicate that it is a Loc area where there are a substantial amount of drugs coming in and that are available to the service member. But the price of it is still somewhere from $50 to $60 to $150 for a gram of cocaine, cut six times from pure.

Senator HAWKINS. You mentioned microwave communications, would that be sensitive equipment?

Mr. LAPLANTE. That means very high-tech, sensitive equipment.

Senator HAWKINS. As former director of the counseling centers, how were you personally involved in the testing program?

Mr. LAPLANTE. How was I personally responsible?

At times, I physically went to units and actually participated in unit sweeps in the collection of the urine samples, themselves. I directly was involved in consolidating those urine samples, turned in by those 57 different units at one point, packaging them and sending them to the testing lab in Wiesbaden.

Senator HAWKINS. You mentioned a lot of switching of bottles, of the urinalysis samples.

Mr. LAPLANTE. This was prior to my taking over the program, the biochemical testing consolidated point was located at the 196 Station Hospital at SHAPE, Belgium in Mons, and at that time, the program was under the hospital organization and they had a number of soldiers, I think four soldiers that were involved in consolidating—it was a four soldier program at that time, independent of the regular hospital operation but they were involved in actual switching of the urine samples. They would falsely mark—they would put an individual's Social Security number across the AE form 1892, and when they marked it down, they would not mark per the correct box that responded to the Social Security number or the unit ID number and in turn, it would be kicked out of the system. And administratively there was something wrong, so that the sample was thrown out altogether.

That is an example. Those four soldiers, after we took over the program, and the irregularities were noted, they were reprimanded, and all four soldiers are still in the services today and they are senior NCO's. They were reprimanded in two or three cases, they received nonjudicial actions for that conduct.

Senator HAWKINS. Were they rehabilitated?

Mr. LAPLANTE. They did not need to be rehabilitated they were not involved in drugs. They were involved in taking moneys for switching those samples, taking moneys for making inaccuracies.

Senator HAWKINS. They were never punished?

Mr. LAPLANTE. A lot of that was based on second and third hearsay evidence, and not enough to directly give them jail sentences or kick them out of the services, but enough that they, in turn, confessed to what was going on, to a certain degree and made bargains, but what it really indicates is that for 3 years that the program was under the 196 station hospital operation, we do not know how many real urine positives there were for cocaine, for other drugs and who was or what was going on at the time.

Senator HAWKINS. Senator Nickles.

Senator NICKLES. Madame Chairman, I want to compliment you on having the hearing. I apologize to the witnesses for not catching all of your statement. I was hoping to walk in and catch part of your panel II and panel III, but I am afraid I am going to have to leave before I can catch much of it.

But let me state that I think there is a problem with drugs in the military. As a matter of fact, my military service is not that long ago, and I can recall some problems more along the line of marijuana, maybe not so much with the heavier drugs. I guess we are most concerned about the use of cocaine and heroine as it is more prevalent I think today.

I am interested in finding how common it is, how much of a problem we do have, and I look forward to hearing from our panelists to get their idea of the impact, and then also very much looking forward to seeing what they are talking about doing about it.

We do want to have some improvements made. For example, some of the statistics that we heard bandied about of significant percentages of military personnel being involved in some type of drug abuse, what is being done about it? Is it being cleaned up? Are the tests being made and is discipline being taken on those individuals who were involved with drug abuse? I think that is very important.

So I commend you and I look forward to the statements by not only our current panelists but future panelists to find out what is going on and what is being done about it. So thank yo very much.

Senator Hawkins Thank you, Senator. We tried to make charts today so we could have a graphic display, but as I stated in my opening statement, we were unable to get any figures at all from the DOD, but we will continue working on that.

Back to Mr. LaPlante. Are there problems with long-term storage of the urinalysis test kits? Is there a problem for storing that for a long time?

Mr. LaPlante. Well, in the beginning we had difficulties due to the area of operation where SHAPE Belgium is we had difficulties in getting the samples to the testing lab in Wiesbaden and getting some sort of priority and getting those samples properly handled into the lab.

We, in the beginning, were seeing 7 to 10 days before we could get them to the lab. When I left, we had gotten that down to 3 to 4 days. We were, in fact, using refrigeration and methods to transport so that we could get a viable reading off of those urine positives.

Let me preface some remarks here. Cocaine is soluble, breaks down in urine, and as a result of that, even as the urinalysis sample is being shipped to the lab, the agent or the chemical in the cocaine that shows up in the urine is continuing to break down. But by the time the lab receives a sample, because of the dissipated value of the cocaine, the measurement of the positive might not, in fact, meet standards for levels of it to be positive, such in the case of cocaine, it is 100 nanos. It may, in the case of cocaine, have dissipated its value to well under 40 or 30 nanos for reporting purposes for it to be a positive when they were testing for cocaine.

Senator Hawkins. In our review of this problem, the military stated they send in systems assessment teams to evaluate the quality of the testing programs. Was that ever done while you were there?

Mr. LaPlante. The answer to that is yes, it was done, and it was done on an annual basis. However, they did not look at the mechanics of the program, the collection system and the problems that we were having with the labs and the false positives and the things of that nature.

They looked to see if we were recording the right information on the right logs; if administrative actions on our part in reporting them to local commanders were being properly carried out.

They looked at things such as were we dotting the "i"s and crossing the "t"s but not really looking at the substantive problems that we had to deal with because of the reports that we were getting from the labs.

Senator Hawkins. Was treatment for the substance abusers adequate, in your opinion?

Mr. LaPlante. No, absolutely not. We were a little bit more fortunate than Mr. Mays. We had five people but we serviced 55,000 people that were a cross——

Senator Hawkins. Five people to service 55,000?

Mr. LaPlante. Yes. Service four major areas of operation. At the time that I was there, we not only had the Benelux which included the Netherlands and the Department of Defense people there, France, the Embassy people. We also had the NORCINC people in Oslo, Norway, and those areas were in our catchment area also along with the civilians and their dependents that were contract defense members to the Benelux area.

Senator HAWKINS. What was the experience level of the counselors at the treatment center?

Mr. LAPLANTE. Fortunately for us, it was a little bit better in our area. We did have a couple of young enlisted people, E-2's, E-3's which with training and involvement—when they first came to us, they were rather green.

Senator HAWKINS. These are the counselors?

Mr. LAPLANTE. These were counselors. Inability to identify. They basically had an inability to even interview people never mind identify that there was a problem existing.

But once we were able to bring them through in-service training, get them to programs in USAREUR, their efficiency and competency level increased markedly, and with continued involvement in the program with people that had problems, their experience level increased.

But by the time you got them trained to where you needed them, it was time for them to ship out. You would spend 2 years training them and in 2 years they would be jolly good clinicians but 2 years somebody else would get your end product.

Senator HAWKINS. What was the average age of the counselor, do you know?

Mr. LAPLANTE. Usually about 18, 19 to about 20, 21, and they were dealing with major substance abuse problems for middle NCO's and other enlisted people.

Senator HAWKINS. What was the average age of the patients?

Mr. LAPLANTE. About 26, 27, in that age. Again, remember, cocaine is an expensive habit. You have to have some sort of income to support that, and we were seeing E-4's, E-5's, and E-6's 3-, 4-, 5-, 6-, 7-year service members involved with the problem.

Senator HAWKINS. The military offers 28-day drug and alcohol rehabilitation for substance abusers. What do you know about that program? Is your experience positive?

Mr. LAPLANTE. Very negative with the exception again Bad Castada and the program in Berlin, two of the very finest programs I think that exist in the military, and by far, the alcohol treatment facility in Bad Castada. I think it is the No. 1 program in the military, better than the Bethesda program.

However, that left the Landshut program, that left the Nuremberg program, that left a number of other programs that were, as I alluded to, understaffed, without real directional therapy programs to interact. They were more enabling facilities than they were cure facilities.

As I alluded to, when we made inspections, we never made inspections during the week. We always made inspections on the weekend and usually late on a Saturday evening between 9 and 3 in the morning we would pop into a facility and that is when you really find out what is going on.

Again, as I said, there were bowling outings where soldiers would be taken to extracurricular activities such as bowling and we would go to the bowling alley and find that the fellows were drinking alcohol. They were drinking beer, and the person that was with them was their community leader.

Now, this was a service member but it was not a staff member. He was a community member.

Senator **Hawkins**. Well, that is not unusual for the military. But you are talking about these are the people in treatment.

Mr. **LaPlante**. These are the people in treatment. OK. We will not go into the military people just yet. But these are military members that were in treatment. They elect a community leader to help with therapy, to be a peer counselor while they are going through the program who is receiving treatment.

In one instance, as I said, the community leaders said, "Well, we are having an outing and we are doing some research into controlled drinking," which was a lot of "BS," and they were all drinking alcohol while they were bowling.

Another instance, on a Sunday evening about 7:30 in the evening, we popped into a facility at Landshut, Germany, and they were conducting an AA meeting. At the AA meeting, they asked us not to go in because it was not an open meeting. However, we could see from the outside that they were showing movies, and the movies that they were showing were porno movies.

We did go in. The director I was with was a captain, and he was insistent. We went in. We put an end to it.

Another example as I alluded to in the speech. We popped into a facility in the Nuremberg area and it was about, I guess, about 9 in the evening on a Saturday, and at that facility when we popped in, we smelled an aura coming from a bathroom area or a communal wash area.

When we went into that area, there were two people that were in the program actually smoking reefers or actually smoking cannabis or cigarettes, cannabis cigarettes. You could smell the odor in the hallways and all you had to do was follow your nose to where it was coming from. Obviously they were surprised.

Senator **Hawkins**. So, in your opinion, it is not a very successful program in that theater.

Mr. **LaPlante**. I would say there are some programs that are successful if modeled after those two programs as I stated before.

Senator **Hawkins**. You stated some are good.

Mr. **LaPlante**. The Landshut program, the Nuremberg program as some examples, I do not think are very successful programs. They are enabling facilities and not curing facilities at that particular time in November.

Senator **Hawkins**. Are you familiar at all with the drug and alcohol situation among civilians who are attached to NATO in Europe?

Mr. **LaPlante**. The answer to that is yes. Again, there were a number of people in incidents that were reported to us and we would see them on the MP blotter or we would see them on the international police blotter, and it was a command policy that those individuals be referred to us.

However, we never saw any of those individuals being referred to us for those problems that came up on the blotters or the international police records. They involved DWI's. They involved driving your car into the main gate while under the influence. They involved domestic quarrels where alcohol was part of the problem.

They involved simple possession, but we never saw those civilians in treatment or we never had referrals to even do screenings for them.

Senator HAWKINS. Are they in sensitive positions in their work?

Mr. LAPLANTE. Some were. Some were involved in communications. Some were administrators, but some were involved in sensitive positions, yes.

Senator HAWKINS. Any of them involved at loading ports of entry?

Mr. LAPLANTE. Yes, at the MTMC in Rotterdam we had at least three or four individuals that were involved in those loading ports.

Senator HAWKINS. How about equipment storage areas?

Mr. LAPLANTE. Yes, there were individuals that were were involved, that are presently under investigation that had major discrepancies in their property book claims, but again, as far as any direct evidence of me having any knowledge of them coming to us for referrals, that did not happen. But there were civilians at the MTMC in the Rotterdam port that did have major discrepancies in their material control books that are probably still today unanswered.

And those people are known to at the time—they are not there now. They have been relieved or they have been sent back home, but they were, because of drugs or alcohol, were part of the problem that was going on with them at the time.

Senator HAWKINS. Are you what the press would call a whistle blower?

Mr. LAPLANTE. What is a whistle blower?

Senator HAWKINS. That is a term used in the media for someone who comes forward and tells what is going on on the inside.

Mr. LAPLANTE. I am not a whistle blower. I have been involved in treatment for 12 years. I am a respected community member. I sit on the Governor's task force for drugs and alcohol in our community. I have been involved with this committee. I have been involved with other Senate committees.

Senator HAWKINS. Well, we are thrilled you are here.

Mr. LAPLANTE. If I am giving information that seems out of the ordinary, those are the things that are happening and something should be done about it.

Senator HAWKINS. Well, I appreciate your being in Florida. We really are happy you are there. You are with a great program. We are very appreciative of your testimony. I think it gives us a glimpse of what the problem is and how severe it is both with the military and civilians, and we like your eight-point program, and we look forward to working with you on a solution.

A lot of people come and tell us the problem. You have the experience and the program that we feel could be put into the military and also as a screening for the civilians, too.

We thank both of you for being with us today.

We will call our next panel, John Beary.

Dr. Beary is presently associate dean at Georgetown University and director of the Georgetown Medical Group. He formerly served as Principal Deputy Assistant Secretary of Defense for Health Affairs.

STATEMENT OF JOHN F. BEARY III, M.D., F.A.C.P., ASSOCIATE DEAN AND DIRECTOR, GEORGETOWN UNIVERSITY MEDICAL GROUP, WASHINGTON, DC

Dr. BEARY. Thank you very much for having me here today.

Senator HAWKINS. I would like to accept your testimony at this time, regarding the Department of Defense Substance Abuse Program.

Dr. BEARY. Thank you, Madam Chairwoman and committee members.

As requested, I have reflected on my tenure at the Department of Defense, where I served from 1981 to 1983. An important responsibility of the Office of Health Affairs is supervision of the overall DOD Drug and Alcohol Abuse Prevention Programs.

Survey data from that period confirmed that our major problems were alcohol abuse and marijuana use. The military and civilian defense leaders expressed a determination to deal effectively with these problems and I know that this commitment continues.

I will first talk about alcohol abuse, because this is the largest problem, whether we are talking about the civilian sector or the military sector.

National data indicate that the problem affects 10 million people, and costs the country $60 billion and is involved in 200,000 premature deaths, per year. Twelve percent of the total national health expenditure for adults is for alcohol abuse.

Of course, I am reminded of this every day as I make rounds at my hospital. About one-third of the people who are at any hospital in the country, have some element of alcohol problems complicating their admission.

Ten percent of most occupational groups have severe alcohol and/or drug dependence problems, and the denial issue that many people comment on when they are talking about these problems complicates efforts to deal with them.

This 10 percent figure applies to pilots, physicians, surgeons, nurses, attorneys, legislators, or almost any group that you might care to name. As we speak this morning, there is an acutely impaired pilot at the controls of a military aircraft and also an impaired civilian pilot who is aloft.

There is at least one impaired civilian and at least one impaired military surgeon at work in an operating room somewhere this morning, somewhere in our country. These are difficult complex problems which defy easy solution, but this does not relieve us from our responsibility to seek and test solutions.

Perhaps having surgeons and pilots blow into a breathalyzer, before starting their critical duties, is too Draconian, but an effective solution can and must evolve.

Some striking statistics germane to today's discussion, include these:

In regard to domestic violence, drowning, and homicides, two-thirds of those are alcohol related.

Auto accidents, you have heard time and time again, that 50 percent of those are alcohol related.

Suicides, 35 percent.

Child abuse, 33 percent alcohol related.

My staff and I analyzed the 10 leading causes of death in active duty military personnel and the associated dollar costs.

Auto accidents were ranked No. 1, with 847 deaths per year in the military.

Suicides were No. 3.

Homicides were No. 5.

And drowning was No. 6.

Heart disease, which ranked No. 2, was the only "traditional medical disease" in that top five, and I have enclosed the two data tables from that article for your review. They make the point that alcohol abuse is a big problem and it is an expensive problem.

Once it became clear that drunk driving, 446 deaths in calendar year 1982, was the No. 1 cause of death in active duty military personnel, our office of health promotion made policy recommendations which culminated in DOD directive 1010-7, on drunken driving which was signed in August 1983.

The second topic that I will discuss is illicit drug abuse.

Survey data and the air crash on the U.S.S. *Nimitz,* in 1981, drew our attention for the need for an intervention to decrease the rate of marijuana use. The risk profile of military marijuana users revealed the following characteristics:

They are mainly under age 25; these people are 63 percent of the total force.

Single marital status, enlisted males and lower educational achievement are additional descriptors.

The above profile describes this particular group. Thus, it was felt that a major deterrent was needed if one were to have a favorable impact on this population.

The urinalysis program, approved by then Deputy Secretary Frank Carlucci, has proven to be such deterrent. The program's components are (1) assure a secure chain of custody for the sample, and (2) biochemical assays, with superb sensitivity and specificity ratings.

The proof of the pudding is that marijuana usage in the young enlisted population fell from 37 percent in 1980 to 22 percent in 1982. Just as an aside, I instructed my staff, that if at any time, a case did not have good chain of custody and good science behind it, we would throw out the case.

Since analysis shows that the major causes of premature mortality in DOD are due to behaviors related to lifestyle, the obvious implication is that improvements are likely to come about through prevention efforts and promotion of healthy lifestyles.

Dr. John Johns, a former line commander in the Army, and my Deputy Assistant Secretary for health promotion, had a keen understanding of the old axiom, "The family fireside is the best of schools." At the time that I left office, he and his colleagues in the services were exploring ways to make use of existing military networks, family groups, the chaplains and the DOD schools to deal with some of the root causes of alcohol and drug abuse.

Effective prevention and health promotion involve much more than what have been the traditional medical activities of preventive medicine and environmental safety. Modifying lifestyles requires fundamental changes in individual values and norms. Therefore, intervention must be made at the community level as well as at the individual level.

A couple of anecdotes, I think are instructive here about the way that good leaders can change individual values and norms.

Gen. John Wickham, now the Army Chief of Staff, when he was commander at Fort Campbell, KY, was very concerned about the number of young people who were losing their lives in drunk driving accidents in that particular part of Kentucky with its narrow roads.

And so he started a program whereby, every Tuesday morning, at 7:30 his assistant brought in the list of anyone in that surrounding area who had been arrested for drunk driving over the weekend, and the miscreants walked in front of him to tell their story and their military boss also walked in front of the general to tell the story and to assure General Wickham as to what was being done to see that he never saw either of them back there again. He had a dramatic impact on drunk driving activities at that post and the death rate.

So I think that this is a good leadership example that shows you can, indeed, change norms and values.

The other example, already alluded to, is, of course, Secretary Lehman and Admiral Watkins, who said it is not going to happen in the Navy. They followup to show that they mean business.

The DOD health promotion effort, in my opinion, should emphasize individual commitment to healthy lifestyles, but also focus on strengthening features of the military community which are conducive to good health.

The medical sociologist, David Mechanic, has identified five categories of such conditions. One, the availability of ample material resources. Two, interpersonal networks of association and support. Three, a reasonable level of skills to cope with ordinary challenges. Four, a personal sense of commitment to some valued ideology or social group. And five, reasonable levels of stability in living conditions.

These things, in turn, affect the individual's motivation and self-esteem and related behavioral factors that may either promote health or contribute to disease if they are not there.

Traditionally the military has sought to provide the first four of these conditions. The similarity of military communities together with activities to welcome new members provides a certain psychological stability in living conditions.

It is possible to build on this tradition by developing cohesive communities with values and norms that promote mental and physical well-being.

In summary, the essence of an effective program to control drug and alcohol abuse is first, an effective data collection system, which is updated at least every 2 years. In addition to prevalence data, information on consequences of abuse should also be gathered.

Second, a urinalysis tool which is legally and scientifically sound.

Third, development of cohesive military communities with values and norms that promote mental and physical well-being.

I thank you very much for the opportunity to comment on this important subject.

Senator HAWKINS. Thank you, Doctor.

Do you feel that the issue of substance abuse is well served in the current Office of the Secretary of Defense?

Does it have a high enough profile?

Dr. BEARY. Well, of course, I have been out of office for a couple of years and not as in close touch with the subject as I was before, but what I read in the medical and the military publications suggests that Secretary Weinberger and the service Chiefs continue to have great concerns and commitment to it. Of course, oversight hearings, such as this, serve to remind everyone to keep putting energy into this important subject.

Senator HAWKINS. Can you comment on the scientific soundness that you mentioned of the Department of Defense urinalysis testing program?

Dr. BEARY. Yes, this was obviously controversial when we started it up and we really looked for all possible solutions to the problem. It was clear that we needed a scientifically sound way of testing a body fluid to find if someone was, or was not using drugs.

As you know, a major issue when you look at such a system, is what is called the sensitivity and specificity of a test. We make life and death decisions every day based on data from hospital laboratories and so these concepts, of course, are very well known and recognized in clinical medicine, but they apply very much to what is going on here. The sensitivity and specificity of these military drug urinalysis tests were excellent. We measured the samples two different technologies, to give some redundancy so that if you said, someone had drugs in their urine, you would be completely confident in your conclusion.

The true test of the the quality of a surgeon or the quality of anything is, "would you have this person operate on you", "would you submit your own urine for testing?"

And indeed, I have that degree of confidence in the system as long as the procedures are followed properly.

I suppose that sensitivity and specificity are rather abstract concepts, if you are not using them in your work every day. I am reminded by seeing the front page of the Post today of the resurrection of some more pseudo science in Washington. I see the lie dectector is up for another run. The concept, of course, is so scientifically flawed so that a discussion of how accurate it is, is somewhat moot.

But to give you a sense, if you go to a library and read what is published in the competent scientific literature about the polygraph/lie-detector machine, you find that the specificity rate, which is the ability to find a negative, is about 50 percent, so that you have 50 percent false positives. Thus 50 percent of the innocent will be misclassified as liars. Now, as I say, in the urine testing, we have rates in the 99.9 percent range. So that gives you a sense of what a good test is and what a bad test is and what good science is and what bad science is.

Senator HAWKINS. Thank you very much.

We appreciate your participating with us on this panel today and ask now that panel three be our last panel.

STATEMENTS OF DR. JARRETT CLINTON, DEPUTY ASSISTANT SECRETARY FOR PROFESSIONAL AFFAIRS AND QUALITY ASSURANCE, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, WASHINGTON, DC, ACCOMPANIED BY MAJ. GEN. WILLIAM SWEET, DIRECTOR, HUMAN RESOURCES DEVELOPMENT, OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL, DEPARTMENT OF THE ARMY, WASHINGTON, DC; COMMODORE J.S. YOW, DIRECTOR, HUMAN RESOURCES MANAGEMENT DIVISION, OFFICE OF THE DEPUTY CHIEF OF NAVAL PERSONNEL, DEPARTMENT OF THE NAVY, WASHINGTON, DC; BRIG. GEN. GAIL REALS, DIRECTOR OF MANPOWER PLANS AND POLICY DIVISION HEADQUARTERS, U.S. MARINE CORPS, WASHINGTON, DC; AND MAJ. GEN. T. BAKER, DIRECTOR FOR PERSONNEL PLANS, DEPUTY CHIEF OF STAFF FOR MANPOWER AND PERSONNEL, DEPARTMENT OF THE AIR FORCE, WASHINGTON, DC

Dr. CLINTON. Madam Chairwoman, and members of the subcommittee, I am pleased to have this opportunity to appear before you today, to discuss the Department of Defense drug and alcohol abuse programs.

We are most pleased to appear before you and to relate our considerable efforts to rid the services of the drug abuse epidemic identified in the 1970's.

I am a physician with board specialty in preventive medicine and public health and I would like to note that I am responsible to Dr. William Mayer, who is the Assistant Secretary of Defense for Health Affairs, and by way of background, and emminent authority in the field of drug and alcohol abuse. He, indeed, established one of the outstanding treatment programs that has been referred to in this session and was previously the Administrator of the Alcohol, Drug Abuse Mental and Health Administration.

Though one always hopes for faster action, we believe that in retrospect, we did take decisive actions based on good data and sound science in a concerted effort to eliminate drug abuse. The progress has been substantial as the numbers will support that. And establishes a strong model for other U.S. groups attempting to reduce drug abuse within their groups.

I would like to summarize the four key actions and the rationale for them.

We developed an epidemiologically sound data base in 1980 with the worldwide survey of drug and alcohol abuse. This survey was repeated in 1982, and demonstrated considerable progress in reducing drug abuse, though the data on alcohol abuse and on smoking were less encouraging.

The worldwide survey will be repeated again this fall, and will provide the primary data base upon which we can make further policy decisions.

Second, command support for the drug abuse program has been extensive and has been demonstrated in a number of ways.

You have already heard the examples of General Wickham, Secretary Lehman. You have seen the financial support statements we have provided for the record: indeed, the budget has tripled over a 5-year period.

We have seen the creation of vigorous programs with the allocation of both military and civilian resources to this considerable effort.

Third, the services have created and sustained a pervasive education and information program. It is directed to every military personnel and it begins with their entrance into the military and is sustained at every military and professional training program and is repeated to them at every permanent change of station.

It takes the form of oral presentations, pamphlets and brochures, of radio presentation and television outside the United States.

Finally, we have developed a very vigorous deterrence program through urinalysis, and it is based on the best science and the best legal judgments to us. With the very capable assistance of Carlton Turner and the White House, the finest toxicologists and chemists provided advice on the various quality enhancements that were, indeed, needed in the urinalysis program. You have heard reference to this in the past, and this group was brought together to find the corrective actions. I am very pleased to report this morning, that these are now well in place, and have been reported to the Senate on an earlier occasion.

The urinalysis program is now scientifically sound and has a strong legal basis. It operates with quality controls maintained by the Armed Forces Institute of Pathology. We employ additional expertise such as the National Bureau of Standards, and we are in regular consultation with the National Institute on Drug Abuse and we will continue that consultation with that institute as well as the National Institute on Alcohol Abuse and Alcoholism.

Madam Chairwoman, we have not yet ridded ourselves of the drug abuse problem, but we know that enemy very well, and our tools are sharpened, and we are confident that we can make continued progress this coming year.

Thank you for this opportunity to present.

Senator HAWKINS. Thank you and your statement will be made a part of the record.

[The prepared statement of Dr. Clinton follows:]

STATEMENT

J. Jarrett Clinton, M.D.
DEPUTY ASSISTANT SECRETARY OF DEFENSE
(PROFESSIONAL AFFAIRS AND QUALITY ASSURANCE)

MADAM CHAIRWOMAN, MEMBERS OF THE SUBCOMMITTEE

I am pleased to have this opportunity to appear before you today to discuss the Department of Defense drug and alcohol abuse programs. I would like to begin with several introductory comments followed by a detailed discussion of our efforts to control drug and alcohol abuse.

INTRODUCTION

The Department of Defense is strongly committed to establishing drug and alcohol abuse programs that ensure the readiness of the Military Services. While it may not be possible to quantify the precise impact of substance abuse on our military's readiness capability, there is no doubt drug and alcohol abuse undermines the readiness of military units. Substance abuse also detracts from the high standards of safety that are required in the handling of sophisticated and dangerous military equipment. Our policies are intended to preserve the health of members of the Military Services by first identifying abusers and then providing appropriate counseling, or medical treatment. Our policies are also designed to permit commanders to assess the security, military fitness, and discipline of their commands and to take appropriate action based upon such an assessment. My office of Professional Affairs and Quality Assurance works closely with the White House Drug Abuse Policy Office, the National Institute on Drug Abuse, and the National

Institute on Alcohol Abuse and Alcoholism. This cooperative effort ensures that we receive the latest information regarding results of research efforts, effectiveness of different treatment programs, and trends in the abuse of various drugs.

MILITARY DRUG ABUSE TESTING PROGRAM

Last year, the Secretary of Defense reviewed the drug urinalysis testing program and submitted a report to the Senate Committee on Armed Services in October. The report included a thorough evaluation of each Service's drug testing laboratory operations and chain of custody procedures. Based on this review, Secretary Weinberger concluded that the drug testing program is sound and that the Services have taken the necessary steps to prevent the recurrence of past procedural problems. To further strengthen the program, Department of Defense Directive 1010.1, Drug Abuse Testing Program, was reissued and became effective on June 1, 1985. The revised Directive includes the following significant policy changes: (1) all drug testing laboratories are required to use radioimmunoassay (RIA) for the initial test and gas chromatography/mass spectrometry (GC/MS) for the confirmatory test; (2) the Services must submit a program specifying the field test equipment to be used, measures to monitor proficiency for each instrument, the training and certification program for the operators, and appropriate chain of custody procedures for handling specimens during field testing; and (3) all presumptive positive results from field test equipment must be confirmed by a certified drug testing laboratory using both the initial and confirmatory tests. In addition, extensive laboratory certification and drug analysis certification procedures, as well as decertification and recertification procedures, are described in the new Directive along with a requirement for annual DoD and quarterly Service laboratory inspections. The implementation of this Directive standardizes laboratory procedures and ensures the legal and scientific supportability of test results reported by the laboratories.

CIVILIAN EMPLOYEES DRUG ABUSE TESTING PROGRAM

The Department also issued Directive 1010.9, Civilian Employees Drug Abuse Testing Program, that was effective on June 1, 1985. As learned from the military drug testing program, urinalysis testing requires careful planning, execution, and oversight. This Directive gives appropriate consideration to civilian personnel law, labor-management relations, the impact on the military program, and constitutional requirements. It specifies that DoD Components have the option to implement civilian drug testing. Before such a program is established, implementing documents must be approved by Dr. Mayer, the Assistant Secretary of Defense for Health Affairs. The program must comply with the guidelines and procedures set forth in this Directive, including informing employees of required participation in urinalysis testing, consequences of a positive test or refusal to cooperate, availability of counseling and referral services, processing specimens using chain of custody procedures, and analyzing specimens by a DoD certified drug testing laboratory. The June 1, 1985 effective date ensures that DoD Component civilian drug testing programs also incorporate the policies in the revised DoD Directive 1010.1 regarding the military program.

REHABILITATION AND REFERRAL SERVICES FOR ALCOHOL AND DRUG ABUSERS

On March 13, 1985 Dr. Mayer issued a revised DoD Instruction on Rehabilitation and Referral Services for Alcohol and Drug Abusers. This Instruction establishes policy for residential, nonresidential and educational awareness programs intended to counsel, treat, or rehabilitate alcohol and drug abusers, and provides criteria for entry into each of the three levels of rehabilitation programs. It also requires that quality assurance measures be implemented in order to comply with Joint Commission on Accreditation of Hospitals (JCAH) standards for alcohol and drug abuse facilities. Service residential and nonresidential programs are required to plan for family involvement in the treatment process, and to include an individualized plan to identify continued support and monitoring following the initial phase of treatment. In addition, DoD Components are required to establish standardized criteria for the selection and certification of drug and alcohol abuse counselors. Licensed health care providers working in direct care, managerial, and supervisory roles over alcohol and drug abuse personnel are required to receive additional training in chemical dependency to augment their competency. Employment Assistance Program (EAP) personnel who provide direct patient care must meet the same certification requirements as active duty rehabilitation personnel. The Instruction also describes the relationship between DoD programs and those of the Veterans Administration, allowing for a referral to the VA when a mutually agreed upon arrangement at the local level is established.

DRUG AND ALCOHOL ABUSE REPORTS

Presently my office is revising DoD Instruction 1010.3, Drug and Alcohol Abuse Reports, which prescribes reporting requirements for drug and alcohol abuse among Department of Defense personnel. We are redesigning the reporting formats to be consistent with the new military drug abuse testing, civilian employees drug abuse testing, and rehabilitation and referral services directives by obtaining data that will identify long term trends and support budget requests for drug and alcohol abuse funds. Results of laboratory and field urinalysis testing will be reported for each drug in the categories of inspection, probable cause, command directed, and medical examination referral in rates per thousand. This information will permit us to assess trends within the Services' programs in the years between the worldwide surveys. The Assistant Secretary of Defense for Manpower, Installations, and Logistics will be responsible for collecting data pertaining to the legal and administrative disposition of offenders, law enforcement, and the costs of accidents, deaths and material damage with drug and alcohol involvement.

WORKSHOPS ON ALCOHOL ABUSE

The abuse of alcohol by military personnel remains a serious problem. My office, in cooperation with the National Highway Traffic Safety Administration, developed a series of 12 workshops that were conducted worldwide to assist personnel in developing local activity programs including topics such as alcohol countermeasures, occupant restraints and motorcycle safety. These workshops will have a lasting and profound effect on DoD personnel through the reduction of injuries and deaths caused by drunk and drugged driving. In addition, thirteen radio and television drunk driving prevention spots were developed by our Armed Forces Radio and Television Service for use on our oversees broadcasting networks.

WORLDWIDE SURVEY

We are continuing our efforts to obtain data that can be used to guide and evaluate program policies by contracting for a third worldwide survey to determine alcohol and nonmedical drug use among military personnel. This third survey has been awarded through the competitive bid process to Research Triangle

Institute in Research Triangle Park, North Carolina. The survey will define the prevalence of alcohol and drug abuse in addition to identifying other critical health attitudes and behaviors. The field survey will be conducted during September and October. Preliminary results will be available by late November with an early 1986 deadline for the final report. Results will be compared with our 1980 and 1982 survey findings as well as with comparable civilian survey data.

CONCLUSION

We have made dramatic progress in reducing drug and alcohol abuse among military personnel since 1980. I believe our success is due primarily to strong command support, extensive education of our personnel, and the expanded urinalysis program. The message is clear. Drug and alcohol abuse will not be tolerated. We still offer rehabilitation and treatment, however, to assist service members who truly desire to overcome their drug or alcohol problem and who have potential for further useful service. We are awaiting the results of the third worldwide survey to determine the effectiveness of our programs since the previous surveys were conducted.

This concludes my prepared statement, Madam Chairwoman. I will be happy to answer any of your questions.

Senator HAWKINS. Major General Sweet.

Major General SWEET. Madam Chairwoman, I am Major General Bill Sweet, Director of Human Resources Development, Department of the Army, and I appreciate the opportunity to appear before you and discuss the Army's Alcohol and Drug Abuse Prevention and Control Program.

The Army is resolved to eliminate alcohol and drug abuse and its adverse effects on readiness. Command involvement, decisive leadership at all levels, coupled with specific policy and program initiatives have been effective in dealing with both aspects of the problem.

Army drug abuse policies emphasize discipline while allowing for rehabilitation when warranted. We require the initiation of separation action for leaders, E-5 and above, the first time that they are identified as drug abusers, and for all second-time drug abusers to include the junior enlisted grades. This policy emphasizes Army intolerance for drug abuse, particularly by leaders. Over the past 18 months, the Army has made major improvements in its drug testing program. Previously identified procedural and managerial problems have been corrected and extensive efforts have been taken to prevent their reccurrence.

The Army drug testing program, including field screening, inhouse and contractor laboratories, is in compliance with all aspects of the new Department of Defense Directive 1010.1.

Inspection reports from DOD, the Army Surgeon General's Office, the Army Judge Advocate General's Office, and an independent consultant to the Deputy Chief of Staff for Personnel in the Army, indicate drug testing laboratories servicing the Army are producing forensically supportable test results.

Data from Army surveys indicate a continued downward trend in admitted drug use and abuse and 55 percent of the admitted drug users report the drug testing program deterred their continued use.

Results from drug testing laboratories and law enforcement information corroborate this trend. The Army is expanding the scope of its drug testing program to include reserve component aviators this summer during annual training and civilian personnel later in the year.

The add-on initiatives are being undertaken with due caution to assure sound policy and procedures are developed for an equitable program without disrupting the Active Army's program.

Army alcohol abuse initiatives focus on deglamorization of alcohol and the individual's responsibility to prevent the tragic consequences of excessive drinking. Reduced pricing of alcoholic beverages at events such as happy hour is prohibited. The Army has set a standard for on-duty impairment at .05-percent blood alcohol content.

The Army has authorized breath testers to detect abuse on duty and established stricter sanctions to combat driving while intoxicated. Effective 20 August 1985, alcohol will not be served to military personnel on duty. The Chief of Staff of the Army and the Secretary of the Army have approved a comprehensive Department of Army alcohol policy reaffirming the direction of these initiatives and providing positive command guidance on the rehabilitation and disposition of alcohol abusers.

We have achieved a measure of success in the alcohol abuse arena. Drunk driving statistics reflect increased enforcement efforts, which are being repaid by a reduction of alcohol related accidents and fatalities. Army survey data show a stable trend in heavy drinking while indicating a decline in moderate drinking.

Rehabilitaiion remains a valid manpower conservation program for those with the potential for future service. In fiscal year 1984, the Army successfully treated and returned to duty over 29,000 soldiers. For the past 3 years, the Army returned to duty over 70 percent of those enrolled in rehabilitation programs. The Army constantly strives to improve the rehabilitation effort through counselor certification and quality assurance programs.

The Army has two ongoing programs geared toward the primary prevention. The U.S. Army Soldier Support Center is implementing a comprehensive alcohol and drug abuse education and training program and the Army is implementing a plan to prevent substance abuse in families through total community involvement.

In summary, the Army is committed to the prevention of alcohol and drug abuse. Our policy and programs are targeted to stress individual responsibility as well as leadership involvement and to strike a proper balance between discipline and rehabilitation. We believe that this prevention oriented approach will continue to further Army readiness in terms of combat power.

Thank you for the opportunity to be here this morning.

Senator HAWKINS. Thank you and your statement will be made a part of the record.

[The prepared statement of Major General Sweet follows:]

RECORD VERSION

STATEMENT BY

MAJOR GENERAL WILLIAM E. SWEET

DIRECTOR OF HUMAN RESOURCES DEVELOPMENT

OFFICE OF THE DEPUTY CHIEF OF STAFF FOR PERSONNEL

DEPARTMENT OF THE ARMY

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS, AND ALCOHOLISM

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

99TH CONGRESS, FIRST SESSION

THE ARMY ALCOHOL AND DRUG ABUSE PREVENTION AND CONTROL PROGRAM

27 JUNE 1985

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RESOURCES
UNITED STATES SENATE

Madam Chairwoman and members of the Committee, I am Major General William E. Sweet, Director of Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army. I appreciate the opportunity to appear before you to discuss the Army Alcohol and Drug Abuse Prevention and Control Program.

The Army is resolved to eliminate alcohol and drug abuse and its adverse effect on readiness. Our program is structured around two basic facets. First, drug abuse is generally defined and treated as misconduct. Data from a variety of sources indicate that junior enlisted soldiers are the primary offenders and marijuana is the overwhelming illegal drug of choice. Use of other drugs is far less prevalent, and very few soldiers are drug dependent. The other facet, alcohol abuse, occurs at all age levels and across all grades and therefore, has a potentially more detrimental effect on readiness. Command involvement and decisive leadership at all levels, coupled with specific policy and program initiatives, have been effective in dealing with both aspects of the problem.

Army drug abuse policies emphasize discipline while allowing for rehabilitation when warranted. We have streamlined separation procedures and require the initiation of separation action for commissioned officers, warrant officers and senior enlisted personnel identified as drug abusers. Although separation is not required, the policy mandates the appropriate senior commander review the separation action to determine if retention in the service is warranted or if other processing is appropriate. Separation action also is required for all second time drug abusers to include personnel in the junior enlisted grades. This policy emphasizes Army intolerance of drug abuse, particularly by leaders in whom special trust and confidence has been placed.

Over the past 18 months, the Army has made major improvements in its drug testing program. Previously identified procedural and managerial problems have been corrected and steps have been taken to prevent their recurrence. One of the measures taken was to reduce the workload on in-house drug testing laboratory operations and supplement their efforts with a commercial contractor. The contractor is required to meet the same rigid specifications as the military laboratories. Concurrently, we expanded the use of field testing devices to enhance commanders' ability to detect and deter drug abuse. The Army drug testing system, to include field screening, is in compliance with all aspects of the new Department of Defense Directive 1010.1. Inspection reports from DOD, the Army Surgeon General's office, the Army Judge Advocate General's office and an independent consultant to the Deputy Chief of Staff for Personnel indicate that drug testing laboratories servicing the Army are producing forensically supportable test results. These results can be used as the basis for disciplinary and administrative actions.

The Army has achieved a creditable measure of success in reducing drug abuse. Data from the May 1984 Soldier Support Center Survey indicate a continued downward trend in admitted drug abuse to the lowest level since we began tracking in 1974. Results from drug testing laboratories and law enforcement information corroborate this trend. Officer and enlisted personnel surveyed overwhelmingly agreed with the "get tough" approach to drug abuse, and 55 percent of the admitted drug users said the drug testing program deterred their continued use. Clearly, progress is being made, and our continued vigilance in this area should facilitate further improvements in the Army war on drugs.

The Army is expanding the scope of its drug testing program. To enhance safety, we began urinalysis testing of Reserve Component aviation personnel during annual training this summer. The testing of this well-defined population will provide the basis for future expansion decisions, while supporting Army readiness and safety efforts. We are identifying critical civilian job categories which may be subject to drug testing under Department of Defense Directive 1010.9. These initiatives are being undertaken with due caution to ensure sound policy and procedures are developed for an equitable program without disrupting the Active Army program.

Army alcohol abuse initiatives focus on the deglamorization of alcohol and the individual's responsibility to prevent the tragic consequences of excessive drinking. Reduced pricing of alcoholic beverages at events such as "Happy Hour" is prohibited. The Army set a standard for on-duty impairment at .05 percent blood alcohol content (50 milligrams of alcohol per 100 milliliters of blood), authorized the use of breath testers to detect abuse on duty, and established stricter sanctions to combat driving while intoxicated. Effective 20 August 1985, alcohol will not be served to military personnel on duty. The Chief of Staff and Secretary of the Army approved a comprehensive Department of the Army alcohol policy reaffirming the direction of these initiatives and providing positive command guidance on the rehabilitation and disposition of alcohol abusers. Specific Army regulations are being modified to implement this policy.

We have achieved a measure of success in the alcohol abuse arena. Drunk driving statistics reflect increased enforcement efforts which are being repaid by a reduction of alcohol related accidents and fatalities. Army survey data show a stable trend in heavy drinking, while indicating a decline in moderate drinking. It is our intent to prevent alcohol abuse; identify, treat, and return problem drinkers to duty; and separate alcohol abusers with no potential for future service.

To deal with identified abusers who have potential, the Army has a three-track, "needs oriented" rehabilitation program. We are equipped to provide education and awareness; group and individual counseling in the non-residential phases (Tracks I and II) in each of our 190 community counseling centers. In the 11 residential treatment facilities (includes beds at two Tri-Service locations), intensive treatment is conducted primarily for alcoholics. Rehabilitation remains a valid manpower conservation program. In FY 84, we successfully treated and returned to duty over 29,000 soldiers. For the last three years, the Army consistently returned to duty over 70 percent of those treated in the rehabilitation program.

The Army conducts quality assurance operations in the rehabilitation program. Consistent with Department of Defense Directive 1010.6, in June 1984 the Army launched a certification program for alcohol and drug abuse counselors. The Army Medical Department Quality Assurance Program has been expanded to cover alcohol and drug abuse in-patient and out-patient care.

The Army has two ongoing programs geared toward primary prevention. The US Army Soldier Support Center is implementing a comprehensive Alcohol and Drug Abuse Education and Training Plan. This is a sequential and progressive program which provides targeted information on Army policy, effects of substance abuse and intervention techniques throughout a soldier's career. The plan is executed through training conducted at service schools, functional courses, and at the unit level. Special courses are ongoing which train health care providers on alcoholism treatment and identification. The Army also has embarked on an effort to prevent substance abuse in families through total community involvement. We have developed a model program for installation commanders and provide expertise through mobile training and assistance teams. US Army Health Services Command has instituted training courses to improve the proficiency of drug and alcohol counselors in dealing with family members.

In summary, the Army is committed to the prevention of alcohol and drug abuse in the Army. Our policy and programs are targeted to stress individual responsibility as well as leadership involvement and to strike a proper balance between discipline and rehabilitation. We believe that this prevention-oriented approach will continue to further Army readiness in terms of combat power.

Thank you Madam Chairwoman. I will be happy to answer your questions.

MAJOR GENERAL WILLIAM E. SWEET

Major General William E. Sweet was born in Toledo, Ohio on 15 September 1929. He received a Bachelor of Science Degree in Education Administration from Bowling Green State University where he was commissioned through the Reserve Officer Training Corps. He subsequently received a Masters Degree in Public Administration from Shippensburg State College in Pennsylvania.

He is a graduate of Basic and Advanced Field Artillery Schools and has attended the Army Command and Staff College and the Army War College.

Early career assignments included duties as the Operations Officer, United States Corps of Cadets, United States Military Academy, West Point, New York; as Commander, 2nd Battalion, 78th Artillery, in Europe and as the Province Senior Advisor, 1st Regional Assistance Command in the Republic of Vietnam.

Upon graduation from the Army War College in June 1975, General Sweet served in the Office, Chief, Legislative Liaison, United States Army followed by a tour of duty as Military Assistant to the Assistant Secretary of Defense (Manpower and Reserve Affairs), Washington D.C.

From May 1977 thru June 1984, General Sweet was assigned to the United States Army Europe. He served as Chief, Officer Personnel Division, United States Army Military Personnel Center Europe; Commander, Division Artillery, 8th Infantry Division (Mechanized) and Chief of Staff, 8th Infantry Division (Mechanized).

In July 1981, General Sweet was promoted to Brigadier General and assumed duties as Chief of Staff, VII Corps, United States Army Europe. From July 1982 thru June 1984, General Sweet served as Commanding General, 56th Field Artillery Brigade, United States Army Europe.

In June 1984, General Sweet assumed his present duties as Director, Human Resources Development, Office of the Deputy Chief of Staff for Personnel, Department of the Army.

General Sweet's decorations include the Distinguished Service Medal; Defense Superior Service Medal; Legion of Merit; Bronze Star Medal; 2 Meritorious Service Medals; an Air Medal; 2 Army Commendation Medals and the Combat Infantryman Badge.

Senator **Hawkins**. Commodore Yow of the Navy who has received great praise today and I am very impressed with your testing.

Commodore Yow. Thank you Senator Hawkins, and good morning to you.

I am Commodore Samuel Yow, Director of the Human Resource Management Division on the Chief of Naval Operations Staff. On behalf of the CNO, I appreciate this opportunity to tell you what the Navy is doing to combat drug abuse. We have made progress and we still need to work harder at it. We have made significant headway in the war on drugs and I welcome the chance to describe to you our aggressive ongoing efforts.

I will briefly discuss our drug program.

The underlying principle in the Navy's war on drugs is summed up in the simple phrase, "Zero tolerance".

Commanding officers may afford junior enlisted personnel identified as first-time offenders a second chance, however, senior enlisted personnel and officers face mandatory dismissal. We have education and training programs emphasizing the concepts of individual and peer responsibility as well as enlightened leadership in preventing and controlling drug abuse.

We have instituted reliable and legally supportable detection and deterrence programs. We have treatment and rehabilitation programs that are geared to help those members in whom the Navy has made a significant investment and who show potential for further productive service.

Overall program effectiveness can be measured by statistics generated in the 1980 and 1982 DOD Worldwide Survey on Alcohol and Nonmedical Drug Use, which reflect a dramatic reduction in the levels of drug abuse. Drug use in general, among junior enlisted personnel, that is E-1 through E-5, dropped from 48 percent in 1980 to 21 percent in 1982, and a continuing downward trend is evident from a Navy survey conducted in 1984, which fixed E-1 to E-5 marijuana or hashish use, the most commonly abused drug, at 10.4 percent down from 48 percent in 1980.

So I am convinced that the actions that we are taking to combat drug abuse are right. The Navy's most valuable resource is our people, the women and men who have volunteered to protect and defend our Nation.

Our zero tolerance policy and the dynamic programs which support it, are working and we will stay on course.

Thank you.

[The prepared statement of Commodore Yow follows:]

NOT FOR PUBLICATION UNTIL
RELEASED BY THE SENATE
COMMITTEE ON LABOR AND HUMAN
RESOURCES

STATEMENT OF
COMMODORE J. SAMUEL YOW, U. S. NAVY
DIRECTOR, HUMAN RESOURCE MANAGEMENT DIVISION
OFFICE OF THE CHIEF OF NAVAL OPERATIONS
BEFORE THE
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM
OF THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
ON
MILITARY DRUG PROBLEMS
27 JUNE 1985

NOT FOR PUBLICATION UNTIL
RELEASED BY THE SENATE
COMMITTEE ON LABOR AND HUMAN
RESOURCES

Madam Chairwoman and members of the Committee:

I am Commodore J. Samuel Yow, Director of the Human Resource Management Division on the Chief of Naval Operations staff. On behalf of the CNO I appreciate this opportunity to tell you what the Navy is doing to combat drug and alcohol abuse. The dangers posed by drug and alcohol abuse are not the exclusive problems of either the military or civilian communities. We are all threatened and we share the common goal of driving this menace from our communities. The Navy has made significant headway in the war on drugs, and I welcome the chance to describe for you our aggressive, on-going efforts. I will first discuss drugs - then focus on alcohol.

The underlying principle in the Navy's war on drugs is summed up in a simple phrase "Zero Tolerance." Navy policy concerning drug abuse is, by necessity, harsh. Commanding Officers may afford junior enlisted personnel identified as first-time offenders a second chance, however senior enlisted personnel and officers face mandatory dismissal. Our drug abuse prevention and control programs are aimed at alerting every sailor to the hazards of drug abuse and ensuring all hands are aware of the personal and professional consequences of abuse. Education and training programs emphasize the concepts of individual and peer responsibility as well as enlightened leadership in preventing and controlling drug abuse. We have instituted reliable and legally supportable detection and deterrence programs. Treatment and rehabilitation programs are geared to help those members in whom the Navy has made a significant investment and who show potential for further productive service.

The Navy's war on drugs is fought on several fronts using various tools and weaponry. On the detection and deterrence front, we employ drug detection dog teams, law enforcement operations and a large-scale urinalysis test program.

The Navy presently has 201 drug detector dog teams dedicated primarily to narcotics suppression. Searches are conducted at base entry points, onboard ships, in barracks, warehouses, and aircraft. Drug dog teams have proven an effective means of sniffing out illegal drugs and a dog team's mere presence is, in itself, a deterrent.

Operating overseas and within the United States, the Naval Investigative Service (NIS) initiated 3,103 narcotics investigations in calendar year 1984. NIS continues to conduct narcotic supression operations in foreign ports visited by Navy ships on deployment. These operations are conducted in concert with local authorities following liaison with the appropriate U.S. Embassy. The operations are aimed at local foreign national drug dealers operating in areas frequented by American sailors and Marines. Stateside, NIS works closely with civilian law enforcement agencies conducting narcotics interdiction operations. These operations normally involve undercover operatives purchasing illicit substances from civilian and/or military personnel trafficking in drugs. As a measure of their effectiveness, NIS operations in 1984 resulted in seizure of narcotics valued at slightly over 1.4 million dollars. (actual figure $1,433,666).

The single most effective weapon in the Navy's detection and deterrence arsenal is the urinalysis testing program. Approximately 1.8 million samples were laboratory tested in FY-84 at five Navy Drug Screening Laboratories, located in San Diego, Oakland, Portsmouth, Great Lakes and Jacksonville. Over 500 portable urinalysis kits are used in the fleet. One civilian lab, CompuChem Inc. located in Research Triangle Park, North Carolina, is under contract to provide confirmation testing of samples found positive for marijuana by portable kit tests. Both the Navy and civilian labs use state-of-the-art gas chromatography/mass spectrometry (GC/MS) equipment for confirmation testing.

Every step in the urinalysis testing process is conducted under careful scrutiny to protect the individual and ensure reliable results. Proper specimen collection and chain of custody procedures are rigorously enforced. In the field, only trained, certified operators can conduct portable kit tests and all positive samples must go to a lab for additional confirmation tests. Navy laboratories follow Standard Operating Procedures which require separate screening and confirmation tests using different test methods before a sample is labelled positive. Navy laboratories are inspected quarterly by the Naval Medical Command and all labs military and civilian, undergo yearly inspections by both DoD teams and civilian forensic experts retained by the Navy. Lab proficiency is continuously monitored through a quality assurance program managed by the Armed Forces Institute of Pathology.

Despite these precautions mistakes can happen and a potential for mistakes, although extremely small, does remain. In the few instances when an administrative or laboratory error occurred or test results were in doubt, we have rectified or resolved the situation in favor of the individual. Furthermore, we rely heavily on the commanding officer's judgment in weighing all factors in a case before pursuing administrative or disciplinary action for drug abuse. We are constantly assessing and improving our procedures and controls to ensure the program maintains its credibility and effectiveness.

To fight a war successfully, one must know the enemy and the Navy is committed to ensuring all hands know the hard facts of drug abuse. Beginning in boot camp and officer candidate schools, new members receive instruction on the dangers and consequences of drug abuse. Formal drug education courses are incorporated into advanced rate training and leadership curricula.

After basic training, all hands must receive continuing or refresher drug education at least every two years. A variety of educational resources help fulfill this requirement. To meet fleet needs outside the classroom environment, 17,000 copies of a new, four-module Drug and Alcohol Abuse General Military Training (GMT) Lesson Plan have been distributed for use at every Navy command.

This lesson plan is incorporated into local seminars and is expected to reach over 500,000 enlisted personnel.

During the past two years, 53,000 Navy members annually attended the Navy Alcohol and Drug Safety Action Program (NADSAP) which is offered at 133 sites. This 36 hour course teaches alcohol and other drug specific information as well as decision-making skills, coping techniques and alternatives for healthier lifestyles.

In addition to general drug and alcohol abuse education programs, the Navy sponsors programs aimed at specific audiences. The Alcohol and Drug Abuse Management Seminar is designed to help commanding officers and supervisors recognize and deal effectively with subordinates' drug and alcohol problems. The Visiting Health Care Professionals Course tailors drug and alcohol awareness information to the needs of Navy doctors, chaplains, lawyers, dentists and nurses.

To facilitate local awareness and prevention efforts, every command Navy-wide must have a Drug and Alcohol Program Advisor (DAPA). This person, usually a senior petty officer or officer, is required to attend an intensive seven day drug and alcohol abuse prevention and control course. The DAPA acts as an advisor to the commanding officer and is a pivotal force in strengthening and sustaining local prevention programs.

It is a time honored Navy tradition that shipmates take care of shipmates and Navy treatment and rehabilitation services reflect this same concern. Primary responsibility for dealing with members identified as drug abusers is placed at the local command level. The commanding officer who made the initial drug abuse determination is in the best position to evaluate the member's potential for future productive service. Based on that evaluation, the commanding officer may take appropriate administrative action and/or initiate corrective education, treatment or rehabilitation. This approach engages the problem at the ship or squadron level where shipmate leadership and peer responsibility are best applied.

Our treatment and rehabilitation programs, which provide intergrated services to deal with both drug and alcohol related problems, operate within a three level escalating structure. This allows maximum flexibility to match the appropriate treatment level to member's care requirements. Level I treatment includes local command education programs and mandatory NADSAP attendance. For first-time offenders who require help beyond the parent command's capability, over 75 Counseling and Assistance Centers are available both ashore and onboard ships. These Level II facilities provide screening services and out-patient counseling. Level III residential rehabilitation programs are offered at four independent Alcohol Rehabilitation Centers (ARCs), 27 Alcohol Rehabilitation Services (ARSs) located within naval hospitals, and the Naval Drug Rehabilitation Center (NDRC) at

Miramar, CA. Since fiscal year 1982, Level III alcohol rehabilitation facilities have treated over 6,000 personnel annually.

The effectiveness and impact of our programs are monitored through various assessment and evaluation techniques, including surveys and reports. Current data gathering capabilities are adequate to meet internal and DoD reporting requirements, but we are taking action to enhance information management. The Alcohol and Drug Management Information Tracking System (ADMITS) is under development with the objective of consolidating alcohol and drug related data to facilitate comparison reporting, trend analysis, research and projection.

Reports from commanders in the fleet solidly support Navy policies and are enthusiastic about the progress we have achieved.

Statistics generated in the 1980 and 1982 DoD Worldwide Survey on Alcohol and Non-Medical Drug Use reflect a dramatic reduction in levels of drug abuse within the Navy. Drug use in general among junior enlisted personnel (E1-E5) dropped from 48% in 1980 to 21% in 1982. Marijuana use, the most widely used illegal drug, dropped from 47% in 1980 to 17% in 1982 for the same group. This same downward trend is reflected in data gathered in three biannual urinalysis surveys conducted for the Navy in Norfolk and San Diego. Marijuana/hashish use among the E1-E5 population closely paralleled DoD Survey data; 48.3% in 1980 and 21.8% in 1982. Our last survey, conducted in 1984, fixed E1-E5 marijuana/hashish use at 10.4%.

While our successes in the war on drugs are gratifying, we are faced with the fact that alcohol is still the number one drug of abuse. In the 1980 DoD Survey, 35% of the Navy's overall population reported diminished work performance due to alcohol abuse. In the 1982 survey, that number increased to 42%. Alcohol abuse results in degraded operational readiness, adverse impact on safety, loss of duty hours and reduced efficiency. In 1983, the CNO reaffirmed the Navy's commitment to fighting alcohol abuse and launched an aggressive Campaign to Counter Alcohol Abuse. The 17 initiatives spearheading the campaign are designed to heighten awareness of abuse, give shipmates in need a helping hand, and provide viable alcohol abuse countermeasures. Actions resulting from these initiatives include:

- generation of new training and education material directed at alcohol abuse prevention.
- increased voluntary attendance at Naval Alcohol and Drug Safety Action Program (NADSAP) and other education courses by senior enlisted and officer ranks.
- special training for club managers and servers.
- instituting anti-DWI effort such as the Designated Driver Program where the person responsible for driving home receives free soft drinks in Navy clubs.
- upgrade of recreational and fitness programs and extended hours of operations at recreational facilities.

I am convinced the actions we are taking to combat drug and alcohol abuse are right. The Navy's most valuable resource is not ships, submarines or aircraft, it is people -- the women and men who have volunteered to protect and defend the nation. We have a reciprocal obligation to protect and defend our people by ensuring they have a healthy, safe, professional environment to carry out their mission. Our Zero Tolerance Policy, and the dynamic programs which support it, help fulfill this obligation. We will stay on course.

COMMODORE JOHN SAMUEL YOW

UNITED STATES NAVY

Commodore J. Samuel Yow, originally from Greensboro, North Carolina, attended North Carolina State University, Raleigh, NC, where he was President of the Class of 1959. Following graduation, he entered Officer Candidate School, Newport, Rhode Island, and received his commission in November 1959.

Commodore Yow's first duty assignment was aboard the USS ANTIETAM (CVS-36). In June 1963, he was designated as Naval Aviation Observer (Navigation) and received orders to VP-18 at Naval Station Roosevelt Roads, Puerto Rico.

Following his tour with VP-18, he was assigned to the office of the Chief of Naval Air Basic Training in Pensacola where he served as as Aide and Flag Lieutenant.

In June 1970, he was assigned to VP-11 at NAS Brunswick where he served as Squadron Tactics and Administrative Officer.

Commodore Yow assumed command of Patrol Squadron TWENTY-SIX in Brunswick, Maine in July 1976. Under his command, VP-26 received the "HOOK-EM" Anti-Submarine Warfare Award from the Commander of the SIXTH Fleet in Europe, the Lockheed Aircraft Golden Wrench Award for the best P-3 maintenance in the Atlantic Fleet, as well as the Captain Arnold Jay Isbell Trophy for Anti-Submarine Warfare Excellence in P-3 Aircraft for an unprecedented second consecutive year.

In August 1977, he was assigned to Washington, DC, where he remained until August 1982. While there, he served in a variety of positions including Head, Aviation Junior Officer Assignments (PERS-432), Head of the Chief of Naval Operations Retention Team and Women in the Navy Programs (OP-136), and finally as Director of Enlisted Distribution (NMPC-40).

He reported to Patrol Wing ELEVEN homeported in Jacksonville, Florida, in September 1982 as the first Naval Flight Officer to command a Patrol Wing.

Commodore Yow served as the Executive Assistant and Naval Aide to the Assistant Secretary of the Navy (Manpower and Reserve Affairs) from June 1984 until assuming his present duties as Director, Human Resource Management Division in May 1985.

Commodore Yow was promoted to Flag rank in May 1985.

The Commodore's awards include the Legion of Merit with two gold stars in lieu of second and third award, the Meritorious Service Medal with gold star in lieu of second award, and the Navy Achievement Medal with gold star in lieu of second award.

Commodore Yow is married to the former Judith Ann Jennette of Pensacola, Florida. They have two sons, Sam and Tom.

Senator Hawkins. Now, we will hear from General Reals.

Brigadier General Reals. Thank you, Madam Chairwoman and members of this subcommittee. I am Brigadier General Gail M. Reals, Director of Manpower Plans and Policy Division, Manpower Department, Headquarters U.S. Marine Corps.

And it is truly a privilege for me to appear before you to present the scope and the impact of illegal drugs in the Marine Corps and our response to that problem.

The admitted high usage rate of 37 percent by Marines, as reported in the 1980 Worldwide Survey on Nonmedical Drug Use, resulted in the Commandant of the Marine Corps establishing a policy of nontolerance for the illegal use of drugs. Consistent with this policy he declared a war on drugs, he did recognize the enemy, that provided the Corps with an innovative program to educate and assist Marines in combatting illegal drug use. This program began in February 1982, and continues today. Its primary objective is to rid the Corps of illegal drugs, not of Marines.

Our program is multifaceted. It provides training and educational courses designed to meet the needs of every Marine. Drug and alcohol awareness are taught in all of our schools and has become a part of our essential subjects training.

A major weapon in our war on drugs has been the urinalysis program. It has been extremely effective in assisting us in meeting our objectives. Initially, there were some startup difficulties at the drug screening laboratories. However, these have been resolved and procedures have been established to preclude their recurrence. It has been operating in an error-free mode ever since. As the level of confidence in the program has improved, more and more Marines have stopped using drugs. The 1983 U.S. Marine Corps substance abuse survey documented that 60 percent of those Marines surveyed indicated that the urinalysis program was a major deterrent in their personal decision to use or not use drugs.

In addition to our emphasis on the preventive education and urinalysis program, the Marine Corps has aggressively pursued other measures, such as drug detection dogs, health and welfare inspections, and random motor vehicle searches. Leaders are encouraging Marines to insist on a drug free environment.

The 1983 survey also gave us dramatic evidence that our programs are working, by showing further reduction in admitted usage rate to 17 percent from the 1980 high of 37 percent. I should note that based on current drug detection rates, we estimate the usage rate is now less than 10 percent. We believe that the upcoming 1985 DOD survey will further document this reduction.

Similarly, we have made tremendous positive strides in addressing the alcohol abuse problem. Our achievements in this area are summarized for you in our statement for the record.

The Commandant of the Marine Corps firmly believes that Marines want and deserve a drug free environment and we intend to see that they have it.

The Marine Corps is very proud of its achievements. Marines must always meet the highest standards and we have succeeded in this area.

Thank you very much.

Senator Hawkins. Thank you and your full statement will be made a part of the record.

[The prepared statement of Brigadier General Reals follows:]

STATEMENT OF

BRIGADIER GENERAL GAIL M. REALS

UNITED STATES MARINE CORPS

DIRECTOR, MANPOWER PLANS AND POLICY DIVISION
MANPOWER DEPARTMENT

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

CONCERNING

SCOPE AND IMPACT OF DRUGS AND ALCOHOL IN THE MILITARY

ON

27 JUNE 1985

NOT FOR PUBLICATION UNTIL RELEASE BY THE
SENATE LABOR AND HUMAN RESOURCES COMMITTEE

Madame Chairman, distinguished members of the subcommittee:

It is a privilege for me to appear before you and to present the scope and impact of drugs in the Marine Corps and our response to the problems.

In late 1980, the Marine Corps was faced with an admitted illegal drug usage rate of 37 percent based on The Worldwide Survey of Nonmedical Drug Use and Alcohol Use Among Military Personnel, 1980 conducted by DoD. In response to this finding, the Commandant established a policy of nontolerance for the illegal use of drugs. Consistent with this policy, a "War on Drugs" was declared that provided the Corps with an innovative program to educate and assist Marines in combating drug abuse. This program began in February 1982 and continues today. It is designed to rid the Corps of illegal drugs, not Marines.

Our program provides training and educational courses designed to meet the needs at every level of command. Drug and alcohol abuse awareness is taught in all the Marine Corps Schools and has become a part of our Essential Subjects curriculum.

The Commandant of the Marine Corps firmly believes that Marines want and deserve a drug free environment and we intend to see that they have it.

The urinalysis program has proven to be extremely effective in assisting us to meet our objectives. Initially there were some start up difficulties at the drug screening laboratories. These difficulties have been resolved and new procedures have been initiated to preclude their recurrence. The urinalysis program now appears to be operating in an "error free" mode. As confidence in this program has developed, more and more Marines have stopped using drugs. The 1983 U.S. Marine Corps Substance Abuse Survey reveals that 60 percent of those surveyed indicated the urinalysis program was a major deterrent to their personal use of drugs.

In addition to our emphasis on preventive education and the urinalysis program, the Corps has aggressively pursued other measures, such as, drug detection dogs, health and welfare inspections, and random motor vehicle searches. Leaders are encouraging Marines to insist on a drug free environment.

The Corps now has dramatic evidence that the programs are working. The 1983 U.S. Marine Corps Substance Abuse Survey documented a reduction in the usage rate to 17 percent from the 1980 high of 37 percent, with an estimated current rate of less than 10 percent, based on the detection rate at the Drug Screening Laboratories. We believe that the upcoming 1985 DoD survey will document still further declines in drug abuse.

Similarly, we have made tremendous positive strides in addressing the alcohol abuse problem. The results indicate a reduction in the alcohol per capita consumption rate by one third since 1980, and a reduction in the number of heavy drinkers (6 or more drinks per day) by 50 percent. The total number of drinkers remained relatively constant, but the number of light to moderate drinkers increased proportionally. This has been accomplished by developing and implementing reasonable and enlightened policies based on responsible drinking of alcoholic beverages.

Since the consumption of alcohol is both a legal right and an individual choice, we have not declared a war on alcohol but rather pursued a course of responsible drinking, holding the individual accountable for his or her actions. We have conducted an extensive alcohol awareness program in which we distinguish between alcohol abuse, a chosen behavior not tolerated, and alcoholism, a disease normally treated. We now track alcohol related incidents and provide counseling and evaluation when indicated. We strictly enforce our drunk driving regulations and require that a civilian conviction of this offense become a part of the individual's permanent records. Finally, and most importantly, we have held each Marine responsible for his behavior and have asked him to examine his own drinking behavior in terms of military readiness to assure it is and remains responsible behavior.

Deglamorizing alcohol has been a major aim of our program, and our commanders are encouraged to provide healthy alternatives for all Marines. We have afforded treatment and rehabilitation to those affected by the disease of alcoholism, and 85 percent of those treated are able to return to full duty.

Recently, we have implemented a new DoD policy which requires Marine installations to comply with the minimum drinking age of the State in which the installation is located.

The Marine Corps is proud of its achievements in controlling drug and alcohol abuse. Marines must meet the highest standard, and we are succeeding in this area.

UNITED STATES MARINE CORPS
DIVISION OF PUBLIC AFFAIRS • HEADQUARTERS MARINE CORPS
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BRIGADIER GENERAL GAIL M. REALS, USMC

Brigadier General Gail M. Reals is the Director, Manpower Plans and Policy Division, Headquarters Marine Corps, Washington, D.C.

General Reals was born September 1, 1935 in Syracuse, N.Y. She attended school in Manlius, N.Y., and Powelson Business Institute in Syracuse, N.Y.

Entering the Marine Corps on Sept. 30, 1954, she completed Recruit Training at Parris Island, S.C., and was assigned as a stenographer at Marine Corps Schools, Quantico. In November 1955, she transferred to Headquarters Marine Corps, Washington, D.C., and served three years as a secretary in the office of the Chief of Staff.

During January 1959, she transferred overseas for a two-year tour at Headquarters, U.S. European Command, Paris, France, for duty as chief clerk, J-3, Operations Section. Returning to the United States in January 1961, she served as private secretary to the Assistant Commandant of the Marine Corps.

She was accepted for the Woman Officer Candidate Class in June 1961, and upon completion of training in September 1961, was commissioned a second lieutenant.

Following her commissioning, she was assigned as Executive Officer, Woman Marine Company at Quantico. She returned to Headquarters Marine Corps in December 1963, for duty as Commanding Officer of the Woman Marine Company and Adjutant, Women Marine Detachment.

From January 1964 until December 1966, General Reals was the Commanding Officer, Woman Marine Company, Headquarters Battalion, Henderson Hall.

She attended the WAC Officer Career Course, WAC Training Center, Fort McClellan, Alabama, from January to June 1967, and upon completion of school spent five months as an instructor at the Woman Officer School, Quantico. She was next assigned as the Base Adjutant, Marine Corps Base, Twentynine Palms, Calif., from November 1967 to October 1968.

Following this short tour, she became the Personnel Officer, Company B, Marine Security Guard Battalion, Beirut, Lebanon until December 1970.

Reporting back to Parris Island in January 1971, she served as Executive Officer, Women Recruit Training Battalion, until June 1973.

General Reals completed the Marine Corps Command and Staff College at Quantico in June 1974, then returned to Headquarters Marine Corps, as the Head, Administrative Branch, Inspection Division. During July 1977, she returned to Parris Island to command the Woman Recruit Training Command.

In October 1979, she returned to Headquarters Marine Corps for duty as head, Human Resources Branch, Manpower Department, serving in this assignment until August 1981, when she was selected to attend the Naval War College, Newport, R.I.

Upon graduation, General Reals returned overseas for duty as the Assistant Chief of Staff, G-1, 1st Marine Aircraft Wing, on Okinawa.

Transferred back to Quantico in August 1983, she served as the Assistant Chief of Staff, Personnel and Services, Education Center. She then served as the Assistant Chief of Staff, Manpower, Marine Corps Development and Education Command until December 1984. She assumed the position as Chief of Staff, Marine Corps Development and Education Command on Dec. 10, 1984. While serving in this assignment, she was selected in February 1985 for promotion to brigadier general. She was advanced to her present grade on May 15, 1985, and assumed her current assignment on June 21, 1985.

Her previous promotions include: first lieutenant, December 1962; captain, July 1966; major, September 1969; lieutenant colonel, February 1975 and colonel, August 1980.

Her decorations and medals include: the Navy Commendation Medal, Army Commendation Medal, Navy Achievement Medal, Good Conduct Medal (second award), three Meritorious Unit Citations, and the National Defense Medal.

Brigadier General Reals is the daughter of Mrs. Anna Reals and the late Clarence Reals of Fayetteville, N.Y.

(Revised June 24, 1985 HQMC)

Senator **Hawkins**. General Baker?

General **Baker**. Thank you, Madam Chairwoman.

I, too, appreciate the opportunity to make public before your committee the progress that is being made by the U.S. Air Force to combat drug and alcohol abuse. As you suggested, I will submit a very full statement and will just summarize in these brief introductory remarks.

We continue maximum pressure in the Air Force to reduce the negative impact of substance abuse on Air Force readiness. Comprehensive education, identification and rehabilitation programs coupled with stern punitive actions have been orchestrated to make substance abuse less attractive to Air Force members.

Our central theme has not changed, simply stated, drug and alcohol abuse is incompatible with the Air Force mission and we hold our commanders responsible for insuring our program is properly administered.

In describing the current drug and alcohol environment in the Air Force, I would emphasize two points, first, our drug abuse prevalence rates as measured by the 1982 Research Triangle Institute's study and it is validated by our own data gathering, have dramatically declined.

For example, that survey showed that percentage of Air Force members reporting the use of marijuana within the past 30 days had declined from 14 to 9.6 percent.

Among our higher risk group, that is, the group that is 25 years or less in age, that decline had been from 20 to 15 percent. A positive trend that we continue to enjoy today and again, we expect that 1985 survey to validate that.

And second, while this study confirmed the success of our efforts in drug abuse, the alcohol trends are less encouraging. As a high tech service responsible for the two legs of the nuclear triad, we fully appreciate the mission degradation that can come from substance abuse. Consequently our commanders keep a watchful eye for signs of such abuse and take swift action when it occurs.

Likewise, our rehabilitation program supports our readiness posture. It is keyed to the early identification of abusers and is reserved for those drug and alcohol abusers who clearly demonstrate a potential to return to successful service.

The foundation of our program is our personnel reliability program. As a principal tool of commanders, the PRP is a vital safeguard to assure that members who perform duty with any component of nuclear weapons are free from substance abuse.

This program receives attention at all levels of command and provides for a systematic method for removing members identified as substance abusers from access to nuclear weapons and other sensitive materials.

The focus of this program is reinforced by a comprehensive no-notice inspection system that has prevented substance abuse from measurably limiting any Air Force unit from accomplishing its assigned peacetime or wartime mission.

With the advent of the capability to test urine for marijuana in 1981, coupled with the ability of our commanders to take increased disciplinary action and to characterize discharges based on these test results, urinalysis has now become the major deterrent against drug abuse in the Air Force.

Since 1981, we have invested close to $11 million in urinalysis lab equipment and personnel and we are currently budgeting over $4 million a year in this activity. We currently process over 200,000 urine samples per year, and we will reach our planned capacity of 300,000 per year in 1987. At that level, we will have the numerical capacity to test each Air Force member on a biennial basis. Given the high quality of the Air Force recruit and the positive effects of our education and discipline programs we believe that this level of testing provides us with the optimum identification and deterrent program.

With regard to alcohol abuse, our field commanders are conducting stronger prevention, education, and rehabilitation programs, and are separating abusers who will not or cannot be rehabilitated. We have expanded our alcohol awareness education programs to encourage more aggressive supervisory identification. We have formalized family assistance and support services to alleviate alcohol problems. We have strengthened our residential treatment programs for those members who become alcohol impaired, and we conduct an alcohol abuse awareness training program for senior officers, and we have instituted special family and substance abuse workshops for health care professionals.

Further, we have greatly emphasized our emphasis against drunk driving, by cracking down on DWI offenders. Following the lead of the August 1982 DOD conference, we have launched a comprehensive Air Force anti-DWI program, the goals of which are to reduce injury and death among Air Force military personnel attributed to alcohol by 10 percent per year for the next 5 years.

In summary, Madam Chairwoman, the combination of the technical ability to detect marijuana through urinalysis and the ability to employ the results of disciplinary proceedings has contributed significantly toward a major decline in drug abuse in the Air Force.

With respect to alcohol, we will continue to develop innovative ways to meet this growing and persistent challenge and we will continue to use all the resources available to provide our men, women, and families freedom from the serious effects of drug and alcohol abuse and to reach and maintain high standards of combat readiness in the Air Force.

Thank you for this opportunity to speak on this.

Senator HAWKINS. Thank you.

[The prepared statement of General Baker follows:]

DEPARTMENT OF THE AIR FORCE

PRESENTATION TO

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

THE SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

SUBJECT: THE SCOPE AND IMPACT OF DRUG ABUSE IN THE MILITARY

STATEMENT OF: MAJOR GENERAL THOMAS A. BAKER
DIRECTOR OF PERSONNEL PLANS
UNITED STATES AIR FORCE

JUNE 27, 1985

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BY THE COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

Madam Chairman and Members of the Committee:

I appreciate the opportunity to appear before this committee to discuss the efforts made by the United States Air Force to combat the effects of drug and alcohol abuse. We are continuing our steady, tough, no-nonsense approach to combat the negative impact of substance abuse. We have refined the comprehensive drug and alcohol abuse control programs we began more than a decade ago to meet the needs of a changing Air Force environment. Throughout this period the central theme of these programs has not changed: drug and alcohol abuse is incompatible with the Air Force mission and we hold commanders responsible for preventing it. We continue to expect commanders to initiate swift, firm disciplinary action when drug abuse occurs, to provide both discipline and rehabilitation to those drug abusers who possess the potential for further useful service and to separate those who cannot or will not maintain standards.

Senior leadership interest, support and guidance for the drug and alcohol abuse programs have been a constant theme in the Air Force and the key to our success. We hold unit commanders responsible for program implementation and believe that deterrence of abuse can succeed only through strong leadership and individual commander involvement and commitment. Our commanders fully understand that aggressive pursuit of drug and alcohol abuse problems is an integral part of their responsibility.

To enhance the ability of our senior leaders to reduce alcohol abuse we offer an annual alcohol orientation program to newly promoted Brigadier Generals and senior staff officers. This program was designed to provide senior leaders with an experiential orientation regarding such topics as the dynamics of alcohol addiction, techniques for intervention and treatment models.

Our comprehensive prevention and education program elements have greatly contributed to lowered drug abuse levels. Our first means of preventing drug and alcohol abuse is to ensure that we do not access new members with abuse histories. Any use of LSD, narcotics, or dangerous drugs, or a conviction for drug possession or trafficking (including marijuana), or current unarrested alcoholism are disqualifying for enlistment or commissioning. Pre-service use of marijuana alone is not disqualifying, although applicants for Personnel Reliability Program positions must not have used it within six months. Before enlistment, all applicants must acknowledge in writing their understanding of Air Force standards. Accession policy toward drug and alcohol use helps ensure we do not induct drug or alcohol dependent individuals.

Our efforts to maintain a drug-free force continue well beyond accession. Beginning with accession training programs, including Basic Military Training School, Reserve Officer Training Corps, Air Force Academy, Officer Training School and our direct commissioning programs, each member attends a

Drug/Alcohol Education (DAE) program. Following this training, all members receive a minimum of two hours DAE within 60 days of their arrival at a new duty station. While education at a new duty station continues throughout a member's career, more specific DAE information is integrated into each of our three levels of officer and four enlisted professional military education programs. In addition, members involved in a drug or alcohol related incident attend an eight-hour awareness seminar which is both educational and rehabilitative.

Other Air Force programs and initiatives contributing to our prevention and education effort include: the publication of drug and alcohol abuse information in internal media, especially base newspapers; the Air Force-wide distribution of literature, pamphlets, etc., produced by the National Institute on Drug Abuse and National Institute on Alcohol and Alcoholism; distribution of commercially produced literature and films; and special presentations by our drug/alcohol abuse control specialists to wives' clubs, civic organizations and community schools.

Our current benchmark of drug and alcohol abuse prevalence levels is the 1982 DoD survey conducted by the Research Triangle Institute. The survey reported that our drug abuse rates dramatically declined; fewer of our people were abusing drugs then than at any preceding time. It is important to note, this data collection will be conducted again this Fall, when the 1985 DoD Survey is administered world-wide. We anticipate the results to confirm the general downward trend in drug abuse among Air Force personnel observed since 1982. While these rates and trends confirm the ongoing success of our efforts to reduce the impact of drug abuse, the prevalence of alcohol abuse among Air Force people increased. This latter finding is disturbing and underlines the necessity to keep seeking solutions to the problem of alcohol abuse.

With regard to substance abuse and unit readiness I would like to point out, commanders at all levels are attuned to the potential for mission degradation that could result from substance abuse. As previously mentioned, unit commanders are expected to keep a watchful eye for signs of such abuse and take swift corrective action when it occurs. To date we have no indication that an incident of substance abuse measurably degraded mission effectiveness or unit readiness. These facts give us no cause for comfort, but do underscore the effectiveness of our program. Our policy will continue to emphasize that substance abuse is incompatible with the Air Force mission, it will not be tolerated, and we will continue to hold commanders at all echelons responsible for preventing it.

The urine testing program has assumed a key role in the drug abuse control effort. The advent of marijuana testing, coupled with the ability of our commanders to take disciplinary action and to characterize discharges based on properly collected samples has caused urinalysis to become a major deterrent against drug abuse.

During September 1982 the DoD lab system was modified to permit the individual services to operate their own drug urinalysis laboratories. Under this scheme the Army and Air Force began operating a joint drug testing lab system on 1 October 1982 with the goal of providing rapid turnaround and accurate results to commanders. This modified system significantly strengthened our commanders' ability to deter drug abuse. It has provided for increased lab capacity to screen 100 percent of all urine samples for marijuana and it has enhanced the credibility and reliability of urinalysis results to support disciplinary actions and to characterize administrative discharges. Moreover, since 1983, the Air Force Drug Testing Laboratory has been inspected several times, the results of which clearly show the lab accurately identifies drug abuse.

To insure that the Drug Urinalysis Program retains its viability as a credible drug deterrent, we launched a special evaluation project to assess the program's effectiveness. As an example, a special Inspector General, Functional Management Inspection Team visited Air Force installations world-wide to assess local quality control procedures for the urinalysis program. This team also evaluated lab processing procedures, responsiveness to unit commander needs, and the quality of commander responses to urine samples reported to be positive for illegal drugs. We used the results of these inspections to strengthen our drug testing program and ensure its viability as a credible deterrent to drug abuse.

With regard to alcohol abuse, we expect commanders to aggressively conduct strong prevention, education, and rehabilitation programs and to initiate separation processing for those abusers who will not or cannot remain rehabilitated. To reduce the negative impact of alcohol abuse upon work performance, we: during accession screening, review DWI-related information; encourage more aggressive commander and supervisor identification of alcohol abusers; implemented a comprehensive Driving-While-Intoxicated (DWI) Initiatives plan; strengthened the alcohol awareness education program; formalized base level family assistance and support services offered by Drug/Alcohol Counselors, Chaplains and Medical Family Advocacy Officers; increased the number of residential treatment programs for those members who become alcohol impaired; and instituted special family and substance abuse courses for health care providers involved in alcohol prevention.

Further, we have intensified our emphasis against drunken driving. Although the Air Force has always placed emphasis on combating driving while intoxicated (DWI) incidents, our emphasis has previously been fragmented. Following the lead of the August 1982 DoD DWI Conference, the Air Staff convened a DWI Task Force in September, 1982. In Dec 82, the Chief of Staff set the tone for the Air Force DWI Program and a comprehensive USAF DWI Program Initiatives Guide established the guidelines for a sustained effort to combat DWI injuries and deaths as well as institutionalize DWI emphasis Air Force-wide. The goals of our program are: to reduce driving while intoxicated injuries and deaths among Air Force military personnel; to change knowledge, attitudes and behavior which affect drunk driving; to establish consistent base DWI programs which incorporate local community efforts; and to provide ongoing internal information and assessment programs.

Our DWI program is progressing well and gaining momentum in the field as new, dynamic initiatives are being independently developed at major command and base levels. We have made significant progress in meeting our program goals. Our initiatives in public awareness, education, countermeasures and enforcement are changing the Air Force environment in relation to our second goal to the point that it is no longer acceptable to drink and drive. Regulations and educational programs throughout the Air Force were revised to include DWI emphasis, accession standards were revised to include a screen concerning alcohol incidents which will specifically ask for DWI-related information, and Air Force clubs implemented dramshop practices. Enforcement and detection within the Air Force has also been increasing as we continue to improve our Security Police training and DWI detection methods.

We are very pleased by the progress our commands and bases have made in establishing effective command and base level DWI programs. All major commands and bases have established local programs using the Initiatives Guide as basis for their program. In many cases, the bases have interwoven their installations programs with local community efforts. Furthermore, we're proud that some of our base personnel have been asked to sit on community and, in the cases of Alabama and Colorado, to take part in state DWI task forces.

We realize such an extensive effort requires constant internal crossfeed and evaluation. Numerous articles have been written in base newspapers and other local media and articles have been published in our "TIG Brief," the Inspection General's publication and "Driver", our safety publication. Public service announcements have become a continuing feature on our Armed Forces television and radio networks overseas. Additionally, many commands have established DWI as a command Special Interest Item for Management Effectiveness Inspections and established DWI Prevention Program Awards.

In summary, the combination of the technical ability to detect marijuana use through urinalysis and the ability to use the results in disciplinary proceedings has contributed toward a major decline in drug abuse among Air Force people. With respect to alcohol abuse we will continue to develop innovative approaches to meet the challenge of this form of substance abuse. We will continue to use all the resources available to us to provide our men, women and families freedom from the serious effects of drug and alcohol abuse. Our goal is maximum deterrence of drug and alcohol abuse and swift, firm action when abuse occurs.

This concludes my prepared statement. I would be happy to answer any questions you may have.

BIOGRAPHY

MAJOR GENERAL THOMAS A. BAKER

Major General Thomas A. Baker is director of personnel plans, Office of the Deputy Chief of Staff, Manpower and Personnel, Headquarters U.S. Air Force, Washington, D.C. He is responsible for all aspects of personnel planning and policy to assure the Air Force of the quantity and quality of trained, motivated people necessary to meet its mission in either peace or war.

General Baker was born May 9, 1935, in Golconda, Ill. He attended Southern Illinois University, receiving a bachelor of science degree in business administration in 1957, and a commission in the U.S. Air Force through the Reserve Officer Training Corps program. The general received a master's degree in business administration from Arizona State University in 1968. He completed Squadron Officer School in 1964; Royal Air Force Staff College, Bracknell, England, in 1970; and National War College, Fort Lesley J. McNair, Washington, D.C., in 1975.

After completing pilot training at Laredo Air Force Base, Texas, General Baker received transition training in F-100s at Luke Air Force Base, Ariz., prior to joining the 50th Tactical Fighter Wing, Hahn Air Base, Germany, in 1960. Following this assignment he returned to Luke Air Force Base as an F-104G instructor pilot in 1963. From January until December 1966, General Baker was assigned to Udorn Royal Thai Air Force Base, Thailand, flying A-1E's.

Upon his return to the United States in 1967, General Baker attended Fighter Weapons School at Nellis Air Force Base, Nev. He instructed in the West German Air Force Fighter Weapons School at Luke Air Force Base during 1968 and 1969.

From January until December 1970, General Baker attended the Royal Air Force Staff College and was subsequently assigned to Wiesbaden Air Base, Germany, as chief of the Rated Officer Assignment Branch, Office of the Deputy Chief of Staff for Personnel at United States Air Forces in Europe headquarters. He commanded the 23rd Tactical Fighter Squadron at Spangdahlem Air Base, Germany, from February 1973 to July 1974. General Baker graduated from the National War College in June 1975, and was subsequently assigned as chief of the Air Force Advisory Mission, Riyadh, Saudi Arabia.

In July 1976 he became assistant deputy commander for operations and later deputy commander for resource management for the 81st Tactical Fighter Wing, Royal Air Force Station Bentwaters, England. The general returned to Germany in September 1977 and served with the United States Air Forces in Europe's inspector general. He was named the command's director of inspection in May 1978. From June 1979 to December 1980, General Baker served as vice commander and then commander of the 48th Tactical Fighter Wing, Royal Air Force Station Lakenheath, England. where he was responsible for the activities of the North Atlantic Treaty Organization's largest tactical fighter unit. General Baker then moved to Ramstein Air Base, Germany, as assistant deputy chief of staff for operations at United States Air Force in Europe headquarters.

When he returned from Europe in August 1982, General Baker was assigned to Air Force headquarters as deputy director of operations in the Office of the Deputy Chief of Staff, Plans and Operations, and in June 1983 he was appointed director of international programs, Office of the Deputy Chief of Staff, Programs and Resources. He assumed his present duties in February 1985.

The general is a command pilot with 4,300 flying hours in a variety of tactical aircraft. His military decorations and awards include the Legion of Merit, Bronze Star Medal, Meritorious Service Medal with two oak leaf clusters, Air Medal with one oak leaf cluster, Air Force Commendation Medal with two oak leaf clusters, Air Force Outstanding Unit Award Ribbon, National Defense Service Medal, Armed Forces Expeditionary Medal, Vietnam Service Medal with three service stars and Republic of Vietnam Campaign Medal.

He assumed the grade of major general Feb. 1, 1985.

General Baker is married to the former Beverly Rudy of LaCenter, Ky. They have two children: Laura and Doug.

Senator HAWKINS. Thank you.

Commodore Yow, it is my understanding that the Navy conducts urine analysis testing for THC, cocaine, opiate, amphetamines, barbiturates, and PCP, is that correct?

Commodore YOW. Yes, ma'am, it is.

Senator HAWKINS. Why do you test for six drugs?

Commodore YOW. Well, our tests are such that it is picked up. Our policy in the Navy is to test every unit, about 20 percent of every unit every month, and this equates to about 1.8 million tests per year.

In our drug labs, not only do we test for marijuana or THC which is the most prevalent. I would say about 75 percent of all positive test results are composed of marijuana. Following that is cocaine, which is about another 15 percent and then the other drugs that you mentioned compose about 10 percent of the positive results that we pick up during testing.

But essentially the testing is all encompassing, and it can pick up positive indications of those drugs from one sample.

Senator HAWKINS. So with one urinalysis sample you can test for all six drugs.

Commodore YOW. Yes, and we think it is great that we can do that. It is important that we detect not only marijuana but the other drugs as well.

Senator HAWKINS. Is that a military secret how you do that?

Commodore YOW. No, ma'am, it is not. It is a standardized series of drug testing procedures in our laboratories.

Senator HAWKINS. Let me ask you one further question. My figures show that in 1982 there were 3,385 dismissals from the Navy; in 1984, there were 7,009. However, our figures show there were 60,024 positive tests. Does that mean the difference between 7,000 that was dismissed and the 60,000 positive are rehabilitated?

Commodore YOW. We work hard on the rehabilitation program. Lately, we are taking a harder line on that. I think we see large numbers back in the days that you are talking about because that is when we first started the program. Now, we have started really taking an active interest with our zero tolerance program.

In the past because we had so many people in the Navy that were users of drugs we felt that we needed to take some sort of action to try to rehabilitate them. We are moving away from that in these days. We feel like we are getting about 30 percent of all the people that come into the Navy that have some history of drug usage.

Everyone that comes in from the recruiting commands signs a statement saying they understand what the Navy's drug and alcohol policies are. So we are moving away from the treatment area and we are just simply starting to not keep those people that cannot comply with our policies.

Senator HAWKINS. Senator Dodd's concern was that we do not screen for that at recruitment time. Does the Navy screen for that at recruitment time?

Commodore YOW. They certainly do. Yes, ma'am. That is a very sensitive issue for us, and as I said, every recruit that comes in signs a statement acknowledging Navy policy. If they are later found to be abusers for whatever reason, then that is fraudulent enlistment. I have been involved with several cases where we have gone back and terminated the service of those people who lie when they come in.

We just simply cannot tolerate it, and particularly Senator Dodd mentioned the submarine base in New London. I know of two instances up there that we have found people that have made fraudulent enlistment statements, and we terminated their service.

Senator HAWKINS. Well, is the screening we are talking about just a question and answer?

Commodore YOW. No, ma'am, it is not. We go back into their past records, into their histories.

Senator HAWKINS. You do not give a urinalysis at recruitment time?

Commodore YOW. Yes, we do. We give one immediately after they check onboard boot camp. Now, this is a little different urinalysis because it is not punitive. In other words, we do not throw them out if we find that they are positive for marijuana. Those who test positive for any other drug are dismissed.

However, it is used as a basis for their recruit record, and of course, they are very carefully warned and indoctrinated into our policies at this time. But we do go back and check their arrest records, for example, to see if there has been involvements in drugs or alcohol as a civilian prior to coming into the Navy.

Senator HAWKINS. Why would you accept a recruit that tested positive?

Commodore YOW. Well, I think it is a matter of numbers. The realities of life are that a large percentage of the civilian population uses drugs. If we eliminated them all, we would be screening out numbers that we need in the Navy.

However, we are giving them a warning. We are telling them of our policy and keeping those that can comply. Many of the people that come in use it as a kick in high school or whatever, and most of them can conform with our policy and can be made good productive sailors.

But they have got to know the rules, and that is the purpose for testing when they first come in.

Senator HAWKINS. Does that record have any weight when you go to assign these people? Do they mop the deck or do they go to communications school?

Commodore YOW. They could go to either one depending on how they test out as far as their skills are concerned, but it would not stop someone from going to a good program or a good school.

Senator HAWKINS. We have had some fear in the past year for espionage. Do we screen the Navy personel that are aboard ship more often than those civilians that are working on the base, the Navy civilians?

Commodore YOW. Do we screen military more than civilians? The answer to that is, yes, ma'am, we do. We have not really had a good strong civilian urinalysis program. We are in the process of developing one at this time, but we do have a standardized, as I mentioned before, program for the Navy wherein 20 percent of every unit is tested per month. It is a random sampling.

So really someone who is going to take the chance and use drugs on a weekend would never know, for example, if we were going to have a test pulled by Social Security number or whatever on Monday morning.

So we attribute the urinalysis program, and the randomness of it, to the decrease in the number of incidents we have had. We think it is a great program.

But to answer your question, civilians are not tested as much as military.

Senator HAWKINS. Are communications personnel, for example, screened any more often than someone who would not be in as sensitive a position? Do you just go across the board?

Commodore YOW. We go across the board uniformly. Now, if someone in a sensitive position is found to test positive, then he is removed from the sensitive position until a determination as to his or her status is made.

Senator HAWKINS. Dr. Clinton, it is my understanding that last summer a decision was made within the Office of the Secretary of Defense that the magnitude of the substance abuse problem in the military no longer justified a Deputy Assistant Secretary to run it, and in fact, that this post has been dissolved.

And I would like to know what evidence that decision was based on.

Dr. CLINTON. I think the entire facts are not related correctly, Senator. Let me describe. Prior to Dr. Mayer's arrival as the Assistant Secretary of Defense for Health Affairs, there had been four people who were DASD's, Deputy Assistant Secretary of Defense for Alcohol and Drug Abuse Prevention.

Prior to Dr. Mayer's arrival, his predecessor had changed that title to Assistant Secretary of Defense for Health Promotion, in part encapsulating the ideas that Dr. John Beary was describing to you earlier.

Senator HAWKINS. Is that Dr. John Johns who had that job?

Dr. CLINTON. He had that job. That is correct. He had that title, and then it was changed.

Senator HAWKINS. What was his first title? Do you remember?

Dr. CLINTON. Deputy Assistant Secretary of Defense for Drug and Alcohol Abuse Prevention. Prior to Dr. Mayer's arrival, that title was changed to Deputy Assistant Secretary of Defense for Health Promotion which then brought in alcohol and drug abuse as well as other issues of health promotion.

When Dr. Mayer reorganized the office in April of last year, not this year, and placed me in that position, he changed the title to Professional Affairs and Quality Assurance. I am therefore responsible for a wide variety of public health and preventive measures as well as quality in medical care activities which incorporate our alcohol and drug abuse staff.

My deputy has been the deputy to that office for a number of years, Dr. John Mazzuchi, and provides excellent continuity with the past, the problems and the resolution of those issues.

Senator HAWKINS. Where is the decision made as to what chemicals you will test for?

Dr. CLINTON. That is made in our office. We basically provide permission that the services can test for the six drugs that you previously specified to Commodore Yow. We establish the levels.

Senator HAWKINS. Why are not all testing for six?

Dr. CLINTON. I think, based on epidemiology, they ought to test for those things which they believe are going to occur in the greatest numbers. It is a question of resources. It is a question of money.

The Navy has made a decision to add the resources to test for all six. The other two services test for more than THC, however. Recall that the other two services, indeed, test for other than THC on some occasions.

There is nothing that we state which would preclude them from testing more. We simply establish the science for it, the laboratory tests that have to be used, the chain of custody that be used, the quality control that must be conformed with and the levels that must exist both for the preliminary test as well as the confirmation.

Senator HAWKINS. How many people within the Health Affairs have been assigned to deal with substance abuse?

Dr. CLINTON. Beyond myself and my deputy, I have a Ph.D. chemist which is for the first time bringing that sort of analytical expertise to that office. I have a Ph.D. social scientist who works predominantly the treatment side of alcohol and drug abuse.

I have assigned more recently my Ph.D. epidemiologist to work with us on a worldwide survey. I am adding a full-time preventive medicine officer who is a community health nurse.

We do not, in my office, divide jobs into small categories. All of us are working collectively as teams in a matrix organization to deal with all the issues that present to us.

Senator HAWKINS. What other duties do you have? What is professional affairs?

Dr. CLINTON. That term, Senator, primarily refers to liaison, say, with the American Medical Association or with medical societies. I got a call the other day from California with regard to a professional issue.

In a sense, it is a term used commonly in health agencies to incorporate those things which professionals are talking and relating to professionals. Quality assurance predominantly refers to our quality of care in the medical hospitals which has received some attention of late.

I have a staff of five, growing to seven, that assists me with that activity.

Senator HAWKINS. Can you tell me the military rank or the civilian grade of the highest ranking person in Health Affairs who now works exclusively on drug and alcohol?

Dr. CLINTON. Well, the chemist is an O-5 that I mentioned earlier and so is the social scientist. I think that it is not completely accurate, however, to categorize that our total work is directed by those two people.

I spend a large part of my time on this issue; Dr. Mayer who is the senior physician for the entire Department of Defense and I are discussing issues of alcohol and drug abuse daily. In the last week we have spent considerable time together discussing it. I have immediate access to him. So I think you are not counting correctly if you simply look for full-time people.

Senator HAWKINS. It is my understanding that the Office of the Assistant Secretary for Health Affairs has had a 100-percent turnover in its Deputy Assistant Secretary positions in the last 4 years.

Dr. CLINTON. In the last 4 years, I suppose that is probably correct. I do not think that is unusual in Government. When Dr. Mayer arrived, yes, all the Deputy Assistant Secretaries are different.

I came at Dr. Mayer's request. The other two Deputy Assistant Secretaries, one was working in health affairs prior to his appointment. The second one was also working in Health Affairs prior to his appointment. What you are seeing is a number of people who move up in stature.

Dr. John Mazzuchi, for example, my deputy, has been with that same department for more than 12 years.

Senator HAWKINS. Dr. Clinton, in 1978, a congressional committee conducted an investigation into substance abuse problems in the military, and the result so disturbed the committee members that they worked with officials of the Department of Defense to draw up a 12-point program of major new policy initiatives regarding drug abuse.

This is a condensed copy of a very comprehensive plan to combat drug abuse in the military, and I am impressed with the thoroughness of the plan but I do not see impressive results of the policy initiatives.

1978 was a long time ago. The players have changed. The problems stay the same, and actually some statistics say the problem has gotten worse. Do you know what has happened to this 12-point program?

Dr. CLINTON. No, I have not seen that document. But I think that you are underestimating the great progress that has been done. I mean, since that time, finances have tripled for drug abuse and have gone up 60 percent for alcohol abuse.

Dr. Mayer has issued an instruction on alcohol abuse and drug abuse treatment. That was issued only a few months ago. He has a forthcoming message to the entire department with regard to alcohol and drug abuse within health providers.

We have established new science and scientific measures for the urinalysis programs. We now have consistency among all three services, same technology, same levels. I think we have made extraordinary progress and the numbers are down.

Senator HAWKINS. Would you look at the paper that I had delivered to you and review those 12 points? And can you tell me today what was done to follow through on that 12-point program? What has been done?

Dr. CLINTON. The first one was to design and administer a comprehensive personnel survey. We have done two and we intend to do another this fall. That requires about a half a million dollars expenditure every 2 years.

To utilize the Center for Disease Control in Atlanta, GA, I consult with them regularly on a number of things, but I have not talked with them about drug abuse. In my regular consultation with them, I am on some of their advisory panels. I will raise that with them.

Redesign of the current drug reporting system. That is underway. I work regularly with NIDA.

Senator **Hawkins**. Would you give me a report on the update? This was dated 1978. Today is 1985.

Dr. **Clinton**. On that specific point or all 12.

Senator **Hawkins**. Well, we will proceed, but that one especially.

Dr. **Clinton**. Fine.

Let me say more about our reporting system. I realize the importance of obtaining data that provide information regarding the effectiveness of our efforts to combat drug and alcohol abuse. Data have been collected by my office for several years; however, changes in the program have necessitated revision of our regulation on reports that requires the submission of these data. A new directive will assign the responsibility to health affairs for obtaining data on the urinalysis testing program, awareness education and rehabilitation programs for drug and alcohol abuse, and civilian employee drug and alcohol abuse programs. For urinalysis, we will be gathering data on the positive rates for both laboratory testing and field testing of specimens by drug and occasion for test. With this revision, we will be able to examine rate positive per thousand for each service by category of urinalysis, namely probable cause, inspection and commander directed. For treatment and rehabilitation, we will be collecting data on the number of individuals entering awareness education and resident and nonresident rehabilitation programs by pay grade, sex, and referral source, and the number returned to duty or separated from the service. In addition, the Assistant Secretary of Defense for Force Management and Personnel will be responsible for collecting data on the legal and adminstrative disposition of offenders and the effectiveness of the Department's law enforcement efforts.

Direct an accelerated testing of portable urinalysis eqnipment That is available. It can be used to the extent that a service wants it to be used. Its quality control is specified by us and watched closely by us.

Reemphasize to command medical personnel the significance of curtailing drug abuse.

Senator **Hawkins**. Mandatory seminars on drug abuse for both service members and their families.

Dr. **Clinton**. That has been underway for as long as I am aware of the program. Furthermore, it is required in a new health promotion directive which we have in coordination now.

Senator **Hawkins**. Some of them I see you have done.

Dr. **Clinton**. Identify methods to accurately measure the extent of drug abuse by military dependents and determine how well existing dependent programs are responding. We are limited in the degree to which we can, with vigor, survey civilians, including dependents. That is a difficult task.

Our primary measure has been measuring drug abuse and alcohol abuse in the military personnel themselves, and there are a number of requirements placed on us by OMB and others with regard to surveys which would preclude us from easily doing that even if we had available to us the proximate $1 million it would require to do the survey.

Law enforcement personnel issue. I would defer to our people in that regard. I cannot speak to that.

Senator HAWKINS. Fine.

Dr. CLINTON. Again, examining the investigative and prosecutive followthrough, that data is available but it is not under my jurisdiction. I do not have that information.

Establish a Berlin task force to look at antidrug efforts in West Berlin. Since this is several years ago, I am not aware whether that was done or not. I can confirm that for you if you like.

Senator HAWKINS. Please.

Dr. CLINTON. This tenth point is an interesting and perplexing one. It asks for the scientific information that exists on the relationship between drug usage and military performance.

Indeed, that has been the debate of numerous scientific councils. That is to say, whether one could give to human a psychotrophic drug and measure their impaired performance. That are anecdotal experiments, not experiments, anecdotal information that suggests how much one is impaired by alcohol and some psychotropic drugs such as marijuana.

The science of that is very difficult to begin with, how you are going to measure whether someone's impairment with regard to taking apart a rifle and putting it back together is impaired by marijuana.

Senator HAWKINS. How about cocaine?

Dr. CLINTON. Or cocaine or any psychotropic drug. The more alarming concern, I think, Senator, is the ethics of the military giving to volunteers a psychotropic drug and then trying to measure something

I do not think there is an ethic committee in the United States that would approve that experiment, but, yes, Dr. Mayer has discussed it at ADAMHA during his tenure there. We continue to discuss the scientific importance of information like that.

Dr. Niven of the National Institute on Alcohol Abuse and Alcoholism and I have discussed a project that he has in mind there to look at alcohol, a legal drug, and its impairment on driving as well as other complex psycho-motor activities.

I am told by my staff, Senator, that the Berlin Task Force completed its work in either 1981 or 1982.

The Center for Disease Control has been used in our previous epidemiological surveys in 1980 and 1982 in terms of consultation. We consult with them on a great number of things. It never occurred to me that we were not consulting with them quite regularly.

I am told further by Dr. John Mazzuchi, my deputy, that all 12 points of this paper that he was familiar with earlier were reported to Congress in the early 1980's.

Senator HAWKINS. The early 1980's. Did you read the report?

Dr. CLINTON. Did I read the report?

Senator HAWKINS. Yes.

Dr. CLINTON. I have not read the report. I certainly will.

Senator HAWKINS. Thank you.

Dr. CLINTON. Health Affairs will work with the services. That is all I do. I work with the services constantly, and these are my colleagues in the services. We meet regularly, individually and collectively to discuss issues.

Commodore Yow and I were discussing a rather complex scientific issue yesterday. I think there is no impairment to that whatsoever.

Dr. Mayer has, indeed, I think, given great vitality to the Defense Health Council which he chairs with the Surgeon Generals of the services as well as with their civilian counterparts within the services.

That group can discuss on a regular basis any issue at the highest level.

The 12th point. A position has been recommended to the White House for the position of ASD for Health Affairs, Gen. John Johns. Well, Gen. John Johns was, indeed, appointed and had that position for a period of time. He left that position. He retired from Health Affairs, and I have been appointed to assume those responsibilities and others.

Senator HAWKINS. Thank you. General Sweet, it is my understanding that the amount of urinalysis testing is going to be decreased by the Army by 260,000 for fiscal year 1986. Can you tell me why that is being comtemplated?

General SWEET. The budget decrease appears, I think, in a worse complexion than it really is. Our budget increased in 1985. We spent about $2 million to improve our forensic laboratory facilities and caused the bulb we were running in 1984 for Army drugs at about 20.2; 28.8 in 1985; and we are showing 25.4 in 1986.

I would say that based upon our experience with regard to our laboratory results and surveys that have been run in the Army, we are not deemphasizing our war on substance abuse, but we are taking a structured look at it, and we are putting resources against what we feel to be the threat, what our problems are.

And 25.4 million will satisfy our requirement in fiscal year 1986.

Senator HAWKINS. You are going to decrease the number of tests?

General SWEET. About a 9 percent decrease across the board. We have an 1985 target of about 800,000.

Madam Chairwoman, I would like to further clarify this matter. There was a $3 million decrease in the fiscal year 1986 budget request for the drug testing program. A portion of this decrease reflects the absence of one time costs incurred to improve drug testing facilities in fiscal year 1985. The remainder reflects a 9-percent decrease in testing, from 800,000 to 730,000 specimens. In light of the reduction of drug abuse and the improved quality of the force, the Army is taking a calculated risk due to budget constraints. Drug abuse trends will be closely monitored and adjustments made as required.

Senator HAWKINS. Can you tell me who makes the decision in the Army to test for two drugs rather than six as the Navy does?

General SWEET. The decision is a personnel decision, approved by the command of the Army. The decision to do that, if I might expand, we have been testing for two, THC and cocaine. We intend to expand to three. Amphetamines will be included. The issue here is to put our resources where we feel our problem is, and based upon our experience, we feel that these three drugs are, indeed, our target, and we are putting our dollars against that problem.

We do not feel that we have a significant harddrug problem.

Senator HAWKINS. Are you testing for cocaine in Europe?

General SWEET. Yes.

Senator HAWKINS. Would you file those figures with this Committee, please?

General SWEET. Indeed. I can tell you that our experience in laboratory results for cocaine across the Army, and I think they are representative of Europe, are about 0.7, less than 1 percent I would be safe in saying that, I think.

Senator HAWKINS. I would like that supplied by location where you test.

[Information supplied for the record follows:]

Testing For Cocaine

Cocaine testing is being accomplished at the following locations with the indicated results (January - May 1985):

Laboratory (Location Served)	Total Tests	Cocaine Positives	Percent
Wiesbaden, GE (Europe)	96,107	94	0.1
Tripler AMC, HI (Hawaii, Korea, Alaska)	38,708	161	0.4
Ft. Meade, MD (CONUS)	34,506	482	1.4
Compuchem (CONUS)	99,802	714	0.7
Totals	269,123	1,451	0.5

Senator HAWKINS. Do you work with the Surgeon General?

General SWEET. Indeed. The Surgeon General has the responsibility for operating the Army laboratories that support the drug and alcohol program of the Army, and also the Surgeon is responsible for the supervision of contract laboratories that support that function.

We work very closely in oversight along with the Staff Judge Advocate General's Office and an independent civilian consultant paid by the Army to provide oversight to that laboratory complex.

Senator HAWKINS. In 1984, there were 4,935 dismissals from the army for drug related incidents and yet you had 35,514 positive tests for drugs. Does that mean you have that many rehabilitated or where are these people?

General SWEET. We rehabilitate roughly 70 percent of those that are discovered to be abusing. That is a very positive success rate in our judgment.

Our disciplinary program stresses individual responsibility as I said in my statement. The idea of rehabilitation is a command decision. When a junior enlisted member below the grade of E-5 is discovered to be abusing, the first offense, assuming there are no other disciplinary problems, he or she is referred to a counselor for screening to determine if this is a drug dependency or not. If there is no drug dependency, then the individual is referred back to the commander for disposition.

The commander can either refer the individual for counseling or rehabilitation or can recommend the individual for release from the service.

In the case of our more senior leaders, E-5 and above and officers, it is mandatory once the discovery of abuse is established that that individual be processed for elimination from the service.

Senator HAWKINS. I have questions to submit to all of you for the record for the benefit of all the Senators who are in other meetings around the Capitol today.

I have one more question to ask Commodore Yow. We know that drug abuse is not consistent worldwide. Some areas it is more prevalent than others. In some areas drugs are less expensive and easier to obtain.

Does the Navy test for cocaine in Panama?

Commodore YOW. If there is a Navy unit in Panama, Senator Hawkins, it is tested for cocaine along with the others.

Senator HAWKINS. Could you give me the results? I understand that it is much higher in that particular area than anyplace else.

Commodore YOW. I do not have those handy. But I would be happy to provide it for the record.

Senator HAWKINS. Just provide it for the record. Fine.

[The information requested, plus additional statements supplied for the record follow:]

COCAINE USE IN PANAMA

(The information follows:)

Yes, the Navy tests for cocaine in Panama. Urinalysis testing for personnel stationed in Panama is conducted in the same manner as urinalysis testing Navy wide. Samples are screened for cocaine as well as the other five drug categories; marijuana (THC), amphetamines, barbiturates, opiates and PCP. The two largest Navy installations in Panama are the Naval Station at Rodman, approximate population 175, and the Naval Security Group Activity (NSGA) at Galeta Island, approximate population 120.

Urinalysis test results indicate the prevalence of cocaine use by Navy personnel is higher in Panama than elsewhere. Based on Navy wide data, an average of one out of every 200 urine samples sent to a laboratory for testing can be expected to confirm positive for cocaine. For commands in Panama, an average of one out of every 85 samples confirms positive for cocaine. The statistical breakbown is given below:

NAVAL STATION PANAMA/NSGA GALETA ISLAND

	FY-84			FY-85	
QTR	2	3	4	1	2
No. Tested	143	197	296	262	201
Cocaine Positives	2	3	3	3	2
Total Positives	3	3	4	4	2

STATEMENT OF THE UNITED STATES COAST GUARD
BEFORE THE SENATE COMMITTEE ON LABOR, SUBCOMMITTEE ON FAMILY, DRUGS AND ALCOHOL

DRUG USE IN THE MILITARY

The U. S. Coast Guard has a strong antidrug program based on the position that illegal use or possession of drugs constitutes a serious breach of discipline which will not be tolerated. In support of this position, the Coast Guard has developed an extensive drug urinalysis testing program for all of its military personnel. This program has the dual purpose of deterring Service members from a life-style that is not compatible with the goals of the Coast Guard and injurious to the members' health, and the positive detection of those using illegal drugs in order to separate them from the service as expeditiously as possible. The urinalysis program is an integral part of the Coast Guard efforts to deter drug usage by training, inspection, and observation. As a consequence of this program, the Coast Guard has witnessed a decrease in the number of positive confirmatory urinalysis tests from 103 per 1,000 in 1983 to 22 per 1,000 for the first half of 1985.

Each Service member undergoes a comprehensive training program which includes the Coast Guard policy on drug abuse, the physical and psychological damages of drug abuse, and the sources of self-help and assistance in maintaining a life-style free from involvement with, and exposure to, drugs. To reinforce this training, each command has a Drug and Alcohol Abuse Representative who assists both the command and the member in maintaining a drug free Service environment.

Because of the strong commitment that users of illegal drugs do not belong in the Coast Guard, any member found to have been involved in a drug incident must be processed for separation. A General Discharge is specified for possession or use, with less creditable forms of discharge for the more severe cases, such as drug trafficking.

The urinalysis program tests for seven drugs: amphetamines, barbiturates, cocaine, methaqualone, opiates, phencyclidine (PCP), and THC (marijuana). Because of concerns for passive inhalation of marijuana, a level of 50 NG/ML or greater of Δ9 THC has been defined as evidence of intentional use of this substance and constitutes a "drug incident." A reported level of Δ9 THC between 20 NG/ML and 49 NG/ML, while below the specified level for discharge or dismissal, does indicate the member may be conducting a life-style which both endangers his or her health and is incompatible with our policy on drug abuse. These members undergo a 6-month period of retraining in drug awareness and weekly urinalysis testing until readings are zero and there is no further evidence of an incompatible life-style. This program is aimed at preventing a drug incident and helping the member towards a career in the Coast Guard.

The programs described above, which have been successful in reducing the drug incidents with Coast Guard men and women, are the culmination of 5 years constant effort to reduce the use of illegal drugs, from offering rehabilitation upon a member's disclosure of past drug use to today's policy of unequivocal separation of identified users. A short history of this change in policy will explain the evolution of the drug urinalysis program.

From 1980 to 1982, the Coast Guard Drug Exemption Program encouraged members to seek rehabilitation by voluntary disclosure of past illegal drug use. A commanding officer's grant of a one-time exemption, following disclosure, precluded disciplinary action and administrative action other than an honorable discharge. Rehabilitation for members who were retained included counselling, education, and inpatient treatment at U. S. Navy facilities for members diagnosed as drug-dependent. Users detected without voluntary disclosure were subject to disciplinary or adverse administrative action. The Drug Exemption Program failed to convince members using illegal drugs to seek help and cease their misconduct. Very few drug-dependent members were identified or treated and the incidence of drug use did not appear to decline as a result of the program.

At that time, the primary method of detecting illegal drugs was evidence of possession, as no reliable large-scale techniques were available for detecting drug usage by a member. During 1982, however, drug urinalysis screening tests were developed which were capable of being locally administered by commands.

With the availability of screening tests which could be locally administered, and the realization that rehabilitation of drug users was only marginally successful at best, the Drug Exemption Program was cancelled in April of 1982. In its place, the Coast Guard adopted a policy that "illegal use or possession of drugs constitutes a serious breach of discipline which will not be tolerated." Under this policy, chief petty officers and commissioned officers were normally separated from the Service on the first drug incident. Junior enlisted personnel could be retained following a first incident, but had to be provided counselling, education, and/or treatment if retained. As part of this revised policy, a General Discharge was specified as the administrative consequence of drug possession or use, with less creditable forms of discharge for severe cases.

In January 1983, the Coast Guard implemented a Servicewide Drug Urinalysis Testing Program. This program, which remains in effect, requires testing of recruits, Academy cadets, officer candidates, direct commissioned officers, and Class "A" School selectees. All other Service members are tested on a random basis or for probable cause. Samples are first tested for seven drugs by a screening method, then by gas chromatography with mass spectrometry (GC/MS) to confirm intentional drug use. Testing requirements include use of a laboratory certified for GC/MS testing of drugs by a Federal or state agency and maintenance of a complete chain of custody throughout the collection and testing process. Districts and Headquarters units contracted for urinalysis testing services at their level.

In July 1984, Coast Guard policy for disposition of drug users was further strengthened by requiring that any member involved in a drug incident be processed for separation. Commanding officers may recommend retention of E-3's and below to the Commandant in extraordinary cases. No such retentions have been authorized to date.

Also, in July 1984, the Coast Guard required collection of two samples per member. The second sample is stored at the command until the sample submitted to the laboratory tests negative, or until disciplinary or administrative processing of positively confirmed members is complete. The second sample is available if the first is challenged in a Discharge Board or Court-martial for improper chain of custody or laboratory testing procedure. Commands have also tested second samples during discharge processing at the member's request.

In May 1985, the Coast Guard established the policy, previously discussed, of monitoring members whose confirmatory test result is 20-49 NG/ML of THC.

In July 1985, the Coast Guard will implement a Servicewide contract with a single laboratory for drug urinalysis testing. Servicewide contracting ensures fully standardized test procedures, removes administrative burdens from field commands, and will obtain a lower price per screening and confirmatory test through volume testing. The Coast Guard will test 125 percent of the active duty population per year on a random basis plus the mandatory tests noted previously. This totals 67,500 samples to be screened per year.

As noted previously, since implementation of the Drug Urinalysis Testing Program, the incidence of positive confirmatory tests has declined from 103 per 1,000 in FY 83 to 22 per 1,000 over the first half of FY 85.

Because of the policy changes tightening the retention standards to the current position of no retention of a drug offender, the number of drug-related discharges from the Coast Guard has continued to increase from FY 82 to the present. The most frequent disposition of drug users has been administrative separation with a General Discharge, often preceded by nonjudicial punishment, rather than prosecution by court-martial. These avenues offer commanding officers their most expeditious means to rid their commands of drug users.

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Comprehensive Care Corporation

STATEMENT OF

DR. JOSEPH A. PURSCH
CORPORATE MEDICAL DIRECTOR
COMPREHENSIVE CARE CORPORATION

BEFORE THE

SENATE SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

ON

DRUGS IN THE MILITARY

JUNE 27, 1985

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Dear Madame Chairperson and Members of the Committee:

Thank you for this opportunity to discuss alcohol and other drug abuse in the military from the perspective of past efforts and recommendations for change.

I am Joseph A. Pursch, M.D., a psychiatrist who spent some 20 years with the Navy treating alcoholics and drug abusers. I served as the medical member on the Chief of Naval Operations Drug Abuse Team, established the Navy's first overseas alcohol/drug rehabilitation program, and was the director of the Alcohol Rehabilitation Service at the Navy's Regional Medical Center in Long Beach California. Upon my retirement from the Navy in 1980, I became corporate medical director of Comprehensive Care Corporation, a national leader in behavioral medicine and the nation's largest private provider of alcoholism and drug treatment.

Undoubtedly, alcoholism and drug addiction are the top health/behavior problems in the Armed Forces.

o In a 1981 worldwide survey of alcohol and drug abuse among military personnel, seven percent were alcohol dependent and four percent were drug dependent.

o In a 1982 survey, nearly a fourth of the enlisted grades E1-E5 had used marijuana in the past month, and more than a third of the total Armed Forces population had reported reduced productivity due to their alcohol abuse.

o The number one cause of death for Department of Defense personnel is drunk or drugged driving.

Within the last 20 years, the approaches to dealing with alcoholism and drug addiction in the military have shifted dramatically. In 1965, there were no "real alcoholics" or drug abusers in the Navy. Alcoholism and drug addiction were treated as disciplinary problems, resulting in dismissal without retirement

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of any known offender. By the 1970s, the Armed Forces learned that if you treat these chemical casualties as patients with an illness, you end up saving lives, building morale and improving the operational readiness of the fleet. In the Navy, a study was done of treated alcoholics. The recovery rate was 76 percent after two or more years of follow-up. The criteria for recovery involved evaluations by supervisors on the basis of alcohol-related health problems, discipline problems, work performance (which had to be average or above), and any renewed drinking problems. If the individual failed in any of these areas, he or she was considered a treatment failure. By the 1980s, the Navy had treated thousands of such cases successfully, among them 8 admirals, 285 Medical Department officers and hundreds of pilots.

Much of my career in the Navy was devoted to convincing commanding officers that alcoholism and drug addiction are treatable illnesses, to helping them initiate adequate treatment programs, and to establishing physician-training programs. For these reasons, I am concerned about the deterioration in the Navy's program management and treatment philosophy. Today, as a civilian, I receive frequent calls and letters from military personnel who decry what they see as a downgrading of treatment philosophy and the resulting practice of kicking drug abusers out of the Armed Forces, particularly if they are officers.

There appears to be a decline in the number of treatment facilities and, a movement of treatment out of the medical mainstream. I am particularly disturbed by the Navy's decision to transfer responsibility for the Alcohol Rehabilitation Units in Naval hospitals to the line. It is a mistake to remove treatment facilities from hospital locations and turn treatment over to line officers where treatment is given only by alcohol counselors. In the Navy, there used to be 70 Alcohol Rehabilitation Units. I am told that soon there will be only three units left. While the closing of such facilities may make it appear that there is less of an alcohol/drug problem in the military, I guarantee you that is not the case.

What we have, in effect, is less treatment availability and accessibility. Overall, my impression is that in the Navy, the program is now one of crisis counseling and legal disposition, rather than treatment and rehabilitation. These kinds of policy changes appear to be antithetical to the recent Department of Defense's comprehensive instruction which emphasizes that chemical dependency is an illness and that medical supervision is a necessary element of such treatment--a point of view shared by the American College of Physicians, the American Hospital Association, the American Medical Association and many others.

My primary recommendation is to adhere to the Department of Defense's policy established in the 1970s. It says that alcoholism and drug addiction are diseases and should be treated as such. More specifically, we should continue a policy of providing adequate treatment (detoxification in a hospital when necessary) and rehabilitation in a controlled environment with medical/psychological supervision. Treatment should be provided at least once or twice before determining that an enlisted person or officer is to be discharged.

Additionally, we should

1. Recognize that the 1984 National Strategy for Prevention of Drug Abuse and Drug Trafficking which recommends that those who are drug or alcohol dependent be prevented from entering the military, while a logical goal, is unrealistic. When you are dealing with several hundred thousand enlistees, it is difficult to detect dependencies at a pre-enlistment level. Although marijuana is detectable for as long as 30 days, alcohol, cocaine, uppers and downers do not stay in the body long enough to be detected easily.

2. Maintain service-wide random testing, regardless of rank.

3. Provide early diagnosis and treatment, regardless of rank.

4. Provide family members of DOD personnel with rehabilitation and educational services when feasible.

5. Institute educational programs about alcoholism and drug addiction.

Provide a one week mandatory program for all supervisors and prospective commanding officers. Provide a two week mandatory program for all physicians in clinical specialties.

6. Adopt a uniform drinking age of 21 years. As a member of the Presidential Commission on Drunk Driving, I support the commission's position that states should immediately adopt 21 years as the minimum legal purchasing and public possession age for all alcoholic beverages. Congress has passed legislation to encourage states to do so or lose portions of their highway trust funds. If that action is considered good public policy for the civilian population, it is no less appropriate for the military population.

7. Deglamorize Happy Hours service-wide. Innumerable times when I have been in officers' dining rooms, there are big barrels of free wine. But if you want a soft drink instead of wine, you have to pay the full price. The tacit endorsement of drinking is obvious and unwise.

Certainly, the DOD's responsibility is to maintain a high state of military readiness and proficiency. For that reason, it is critical that the Armed Forces--all branches--recognize the dangers of widespread substance abuse to our national security. Appropriate educational, detection and rehabilitation programs must be maintained.

Senator **Hawkins**. We thank all of you for participating today. The military services are proud and a special calling and carries with it distinct responsibilities and duties.

The tragedy of substance abuse is magnified when it involves our fighting forces because they are not only destroying themselves but they are relinquishing their chosen responsibility to defend our lives and freedom.

I have nothing but respect and admiration for our men and women in uniform, and I am certain working together we can be able to make more progress with this problem.

The hearing is adjourned.

[Whereupon, at 12:05 p.m., the subcommittee adjourned, to reconvene, at the call of the chair.]

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